



DESERT STATES EMPLOYERS AND UNITED FOOD & COMMERCIAL WORKERS UNIONS PENSION PLAN

SECOND REQUEST

February 2011

Dear Recipient,

The Trustees have a fiduciary responsibility to confirm that each pensioner or beneficiary is personally receiving their monthly benefit payment, either by check or direct deposit.

In that connection, the Fund procedures require that you complete and return the enclosed form **promptly**.

**PLEASE NOTE THAT THIS IS A SECOND NOTICE. FAILURE TO
RETURN THE COMPLETED FORM PROMPTLY MAY INTERRUPT THE
ISSUANCE OF FUTURE PENSION PAYMENTS.**

A return envelope is enclosed for your convenience.

Thank you for your cooperation. If you have any questions or concerns, please call the Fund Office at 602-249-3582.

Sincerely,

Pension Department
Southwest Service Administrators. Inc.

Enclosure

***Create your own personal login at www.southwestservicetpa.com to view/edit your account, access plan regulations, recent mailings and various forms.
Also available online is the "Electronic Deposit Authorization Form" that may be returned to implement the direct deposit of benefits to your bank account.***

**DESERT STATES EMPLOYERS & UFCW UNIONS PENSION PLAN
2011 ANNUAL AFFIDAVIT**

I personally receive my monthly benefit payment in the form of:

A check delivered to my home A direct deposit transferred to my bank account

Are you presently employed, or have you been employed during the past year?

NO YES

If you answered yes, please complete the following:

Employer _____ Job Title _____

Dates of Employment _____ Full or Part Time _____

Local Union Affiliation _____

Federal Income Tax Withholding

I **do not** wish to change my Federal Tax Withholding amount.

I **do** wish to change my Federal Tax Withholding amount. Please send me Federal form W-4P.

COMPLETE THIS SECTION ONLY IF YOU ARE UNDER AGE 62 AND RECEIVING A DISABILITY PENSION FROM THIS PLAN.

Confirmation of Disability

The administrative procedures of the Fund require yearly updates from all participants under age 62 receiving a Disability pension. **Please submit a copy of your most recent Social Security Disability check or a copy of your 1099 that was provided by the Social Security Administration.**

Are you currently receiving a Social Security Disability Benefit?

YES NO

Have you been able to do any substantial work in the past year? YES NO

NAME _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ xxx-xx-

MAILING ADDRESS _____

CITY, STATE, ZIP _____

TELEPHONE _____

(PLEASE PRINT) NEW MAILING ADDRESS, IF APPLICABLE : _____

CITY, STATE, ZIP _____

I hereby declare under the penalty of perjury that all information shown by me is correct to the best of my knowledge. **An original signature is required for this declaration.**

SIGNATURE

DATE