



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

URGENT – FINAL REQUEST

March 4, 2011

Dear Recipient:

The Trustees have a fiduciary responsibility to confirm that each eligible pensioner or beneficiary is personally receiving their monthly benefit payment, either by check or direct deposit. The enclosed affidavit, when completed and returned by each eligible member, will assist the Board of Trustees in protecting your pension benefit.

We have forwarded this request to you on two prior occasions. This is the third and FINAL request for the return of your completed Annual Affidavit. **This letter will serve to notify you that your pension will be suspended effective May 1, 2011 if your completed affidavit is not received by April 15th.** In order for your pension benefit to be reinstated for any future months, your completed affidavit must be received by the 15th of the prior month.

Please return your completed affidavit promptly to avoid the interruption of your pension benefit. We have provided a return envelope for your convenience.

Thank you for your cooperation.

Sincerely,

Pension Department
Southwest Service Administrators, Inc.

Enclosure

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 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