



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

January 2011

Dear Recipient,

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

Please return a completed affidavit form promptly to assure that your future pension payments are not interrupted. We have provided a return envelope for your convenience.

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

Sincerely,

Pension Department
Southwest Service Administrators. Inc.

Enclosure

www.southwestservicetpa.com

***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.

SIGNATURE

DATE