

**PENSION DEDUCTION
ASSIGNMENT AND AUTHORIZATION REQUEST**

TO: Board of Trustees
IBEW Local 683 Health and Welfare Fund

I, the undersigned, am receiving a monthly benefit from the IBEW Local 683 Pension Fund and am also maintaining my eligibility for benefits under the IBEW Local 683 Health and Welfare Fund by means of self-payments. As a convenience to me and to assure my continued Health and Welfare Fund eligibility, I hereby request and authorize you to deduct from my monthly Pension Fund Benefit whatever amounts may be required from time to time to maintain my coverage under the Health and Welfare Fund as shall be reported to you by the Health and Welfare Fund and to remit such deducted amounts directly to the Health and Welfare Fund.

I understand that I may revoke this authorization at any time by written notice to you, but also understand that at least sixty (60) days advance notice to do so is required.

Name (printed or typed) _____ ID or SS# _____

Street Address _____

City _____ State _____ Zip Code _____

YES - I authorize Pension Deduction for continuing health care coverage.

Date _____ Signature _____

- or -

NO - I do not want Pension Deductions at this time.

Date _____ Signature _____

Except for your signature, please print or type all other information. The amount assigned cannot, of course, be more than your monthly benefit from the Pension Fund.

SEE EXPLANATION ON BACK OF THIS FORM

(For Fund Office Use Only)

Effective Date

Amount of Deduction

Effective Date

Amount of Deduction

EXPLANATION

This Assignment and Authorization Request Form is designed to serve as a convenience to you. Authorizing deductions of self-payments from monthly pension benefits, while purely voluntary, will eliminate the inconvenience and expense of writing checks or obtaining money orders and mailing same to the Fund Office each month and, more importantly, eliminate the risk of losing coverage because of illness, travel, delay in the mail, or whatever reason may prevent you from remitting your self-payment within the prescribed time.

You may revoke this authorization at any time by written notice to the Health and Welfare Fund Office but, such notice must be given at least sixty (60) days in advance. If, however, you wish to end your coverage under the Health and Welfare Fund for whatever reason, you may do so by notifying the Health and Welfare Fund before the first day of the month you wish your coverage to end. In such event, even though self-payments may still be deducted from you pension check for another month or two, you will receive a reimbursement for such self-payments directly from the Health and Welfare Fund.

If and/or when the rates of self-payments are increased, you will be notified far enough in advance to be able to revoke your authorization for deduction if you choose to end coverage under the Health Care Fund.