

REGIONAL DISTRICT COUNCIL  
FRINGE BENEFIT FUNDS

**AUTHORIZATION TO  
TRANSFER CONTRIBUTIONS PURSUANT TO IRON WORKERS  
INTERNATIONAL RECIPROCAL AGREEMENT**

NAME: \_\_\_\_\_  
(PLEASE PRINT)

HOME ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

TELEPHONE: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_  
SOCIAL SECURITY NUMBER DATE OF BIRTH

HOME LOCAL #: \_\_\_\_\_ UNION BOOK #: \_\_\_\_\_

I hereby elect or do not elect as indicated below, to have contributions which are paid on my behalf to the Regional District Council Fringe Benefit Funds, transferred to my Home Local fund(s). I understand that this Authorization is only valid with respect to those Home Local fund(s) that have executed agreements with the Regional District Council Fringe Benefit Funds to permit the transfer of contributions. **No contributions will be transferred for a period prior to 60 days from the date the Regional District Council Fringe Benefit Funds received a participant's authorization to transfer funds.**

**Elect**  **Do Not Elect** to have my **HEALTH** contributions remitted to my Home Local Health Fund

**Elect**  **Do Not Elect** to have my **PENSION** contributions remitted to my Home Local Pension Fund(s). (I understand that if I have more than one Home Local Pension Fund, that contributions transferred on my behalf will be divided between my Home Local Pension Funds in the manner and percentages/amounts decided by the trustees of my Home Local Pension Funds.

I understand that the Regional District Council Fringe Benefit Funds will act solely as the agent of my Home Local fund(s) and as such, I shall be subject to the eligibility/reciprocity rules of my Home Local fund(s) upon the transfer of contributions. I hereby release (on behalf of myself as well as on behalf of anyone claiming through me) and further discharge the Regional District Council Fringe Benefit Funds and their Trustees of and from all claims, demands, actions, causes of actions or suits with respect to any contributions so transferred and for any benefits or credits which would have accrued or become payable to me had I not authorized this transfer of contributions. I further recognize that the transfer of contributions to my Home Local fund(s) may or may not ultimately prove to be to the advantage of myself and/or my beneficiaries.

DATE SIGNED: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(DO NOT PRINT)

**COMPLETED RECIPROCAL FORMS MUST BE RETURNED TO THE FUND OFFICE AT:**

Regional District Council Fringe Benefit Funds  
c/o William C. Earhart Company, Inc.  
P.O. Box 4148 • Portland, Oregon 97208  
Toll Free (800) 846-0611 • Fax: (503) 284-9386

**PLEASE KEEP A COPY FOR YOURSELF AND A COPY TO BE SENT TO YOUR HOME LOCAL FUND ADMINISTRATOR**