



**Southern Operators Health Fund**  
C/O Southern Benefit Administrators, Incorporated  
P.O. Box 1449  
Goodlettsville, TN 37070-1449  
Fax: (615) 859-6792  
**RECIPROCAL TRANSFER NOTIFICATION**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Member of Local **Number** \_\_\_\_\_ Located at \_\_\_\_\_

Working in jurisdiction of Local **Number** \_\_\_\_\_

Located at \_\_\_\_\_

CHECK THE APPROPRIATE BOX

**\*(If you want benefits with the pipeline, write "Pipeline" on one of the spaces below)**

This authorizes the \_\_\_\_\_  
(fund name(s) where work is performed) to transfer to my home fund, the Southern  
Operators Health Fund any and all contributions made.

This authorizes the **Southern Operators Health Fund** to transfer to my home  
fund(s), \_\_\_\_\_ any and all contributions  
made.

SIGNED \_\_\_\_\_ DATED \_\_\_\_\_