HEALTH & WELFARE RECIPROCITY AGREEMENT
Request and Authorization for Transfer of Contributions

_____ _____
Participant Name (print) Social Security Number

I request and authorize the Board of Trustees of the Local _____ Health and Welfare Fund to transfer to my Home Health and Welfare Fund all contributions made on my behalf to its Fund hereafter and six months prior to the date this authorization request is received by the Fund, unless and until this authorization is revoked in writing. In support of this request, I state the following:

1. I am a member of IUOE Local No. _____ and my Union Register No. is: _____.

2. My Home Health and Welfare Fund is: _____.

3. I understand that, upon approval of my request to transfer, I cannot later request that any contributions which may be transfered to my Home Fund be transfered back to the transferring Fund.

4. I understand that, upon approval of my request to transfer contributions, my and my dependents' eligibility for benefits and all other participant rights shall be determined exclusively by the terms of my Home Fund's plan and rules and not by the terms of the transferring Fund's plan and rules.

5. By making this request, I waive and release, on behalf of myself and my dependents, any and all claims against both Funds and their fiduciaries relating to whether the transfer of contributions is in my or their best interests.

_____ _____
Participant's Signature Date

_____
Street Address

_____

_____ _____
City, State, Zip Code Phone Number

If reciprocating hours to Local #49, send to:

Local #49 Health and Welfare Fund Office
3001 Metro Drive - Suite 500
Bloomington, MN 55425