

## **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 any other reason which 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 Fund Office; however, such notice must be given at least sixty- (60) days in advance. If, for some reason, you wish to end your coverage under the Health and Welfare Fund, you may do so by notifying the Insurance Fund the first day of the month you wish your coverage to end. In such event, even though self-payments may still be deducted from your pension check for another month or two, you will receive a reimbursement for such self-payments directly from the Flint Plumbing & Pipefitting Industry Insurance Fund.

Should the rate of self-payment be increased, you will be notified far enough in advance to have the opportunity to revoke your authorization for deductions if you choose to end coverage under the Flint Plumbing & Pipefitting Industry Insurance Fund.

**PENSION DEDUCTION  
ASSIGNMENT AND AUTHORIZATION REQUEST**

TO: BOARD OF TRUSTEES  
FLINT PLUMBING & PIPEFITTING INDUSTRY PENSION FUND

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

\_\_\_\_\_  
Member ID or SS#

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

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
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 Office Use Only)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Class Code

\_\_\_\_\_  
Amount of Deduction

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Class Code

\_\_\_\_\_  
Amount of Deduction

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Class Code

\_\_\_\_\_  
Amount of Deduction