KENTUCKY LABORERS DISTRICT COUNCIL HEALTH & WELFARE FUND

1996 ByPass South
Lawrenceburg, KY 40342

Telephone: (502) 839-8166

Fax: (502) 859-0976 or (502) 839-3558

EMPLOYEE RECIPROCAL AUTHORIZATION FORM

FOR TRANSFER OF HEALTH & WELFARE CONTRIBUTIONS AND HOURS

EMPLOYEE'S NAME: [Please Print]	(First)	(M.I.)	(Last)

TO TRANSFERRING FUND:

NAME OF TRANSFERRING FUND:			
MAIL ADDRESS OF TRANSFERRING FUND:			
TRANSFERRING FUND PHONE #		TRANSFERRING FUND FAX #	

The aforementioned transferring Health and Welfare Fund has received contributions for work performed by aforementioned employee in the jurisdiction of Local # _______ located in ________________________________ (City) ________ (State).

In order to receive Health and Welfare hour credits while working outside my home fund jurisdiction, I hereby authorize the above identified Health and Welfare Fund to receive all contributions for my hours worked within the area covered by the Fund(s) and to transfer such hours to my Home Fund at the contributions rate of the transferring Fund in accordance with the existing reciprocal agreement.
I understand that I will no longer have a claim against the Transferring Fund for any benefits. I also understand that my eligibility for any benefits based on such contributions will be determined solely in accordance with the benefits of my Home Fund.
I understand that the Transferring Fund will act solely as the agent of the noted Home Fund and as such, I shall be subject to the eligibility rules of said Home Fund 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 Transferring Fund and its Trustees from any and all claims, demands, actions, causes of actions 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 any Home Fund may or may not ultimately prove to be to the advantage of myself and/or my beneficiaries.
I hereby release any and all fiduciaries and all others involved in or connected with said transfer from any loss or damages resulting to me or my successors, heirs or assigns by reason of or as a result of said transfer.
This request shall be in effect for all periods of employment within the jurisdiction of this local union until and unless written revocation is submitted to the transferring fund.

EMPLOYEE'S NAME (First, MI Last):			
EMPLOYEE'S ADDRESS: (Street or PO Box, City, State, Zip)			
EMPLOYEE'S HOME LOCAL UNION #:		EMPLOYEE'S DATE OF BIRTH:	
EMPLOYEE'S SOCIAL SECURITY #:		EMPLOYEE'S PHONE #:	
HOME FUND:	Kentucky Laborers District Council Health & Welfare Fund 1996 ByPass South, Lawrenceburg, KY 40342	DATE EMPLOYEE BEGAN WORK IN AREA OF TRANSFERRING FUND:	

Date: ____________________________ Employee's Signature: ____

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IMPORTANT NOTE: Employee must send the appropriate copies of this form to his Home Fund (White Copy) and the transferring fund (Green Copy). He should keep the last copy (Yellow Copy) for his own records.

WHITE COPY – HOME FUND **GREEN COPY – TRANSFERRING FUND** **YELLOW COPY – EMPLOYEE**

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