BRICK MASONS TRUST FUNDS

Bricklayers Local No 4 Southern California

THE BAC RECIPROCAL AGREEMENT

EMPLOYEE RECIPROCAL AUTHORIZATION AND RELEASE FORM

Please check all boxes that apply:

TRAVEL FUNDS

☐ The participating defined benefit pension fund [Named_____,] receiving contributions for work performed in the jurisdiction of BAC Local Union_____, is located at:

_____.

_____.

☐ The participating defined contribution pension fund [Named_____,] receiving contributions for work performed in the jurisdiction of BAC Local Union_____, is located at:

_____.

☐ The participating health and welfare/flexible benefit fund [Named_____,] receiving contributions for work performed in the jurisdiction of BAC Local Union_____, is located at:

_____.

_____.

This authorization is voluntarily given by me and at my instance, and shall remain in full force and effect until I have not worked in the area covered by this pension and/or health and welfare fund(s) for a period of one year or until the last day of the month in which my written request to cancel this authorization is received by the administrator of this pension and/or health and welfare fund(s).

All of the following information must be completed.

SIGNATURE _____ DATE_____ .
(month/day/year)

NAME (Print)_____ HOME PHONE_____.
(area code/number)

HOME ADDRESS_____.
(street) (city) (state)/(province) (zip)/(postal)

SOCIAL SECURITY NUMBER _____ BIRTHDATE_____.
(month/day/year)

SOCIAL INSURANCE NUMBER_____ MEMBER OF LOCAL UNION_____.
(Canadian employees) (home local)

HOME FUNDS

HOME FUND (defined benefit) NAME_____

HOME FUND (defined benefit) LOCATION P.O. BOX 60750 / LOS ANGELES, CA 90060- 0750 JURISDICTION _____.
(city) (state)/(province)

HOME FUND (defined contribution) NAME_____.

HOME FUND (defined contribution) LOCATION P.O. BOX 60750/LOS ANGELES,CA 90060- 0750 JURISDICTION_____.
(city) (state)/(province)

HOME FUND (health & welfare) NAME_____.

HOME FUND (health & welfare) LOCATION P.O. BOX 60750/ LOS ANGELES, CA 90060- 0750 JURISDICTION_____.
(city) (state)/(province)

HOME FUND E-MAIL: staff@socalbrickmasonsbenefits.org

RECEIVED BY_____ DATE_____.
(month/day/year)

FORWARD FORM TO PROPER PLAN ADMINISTRATOR IMMEDIATELY AFTER SIGNING AND SEND A COPY TO THE RECIPROCAL CLEARINGHOUSE.

Mailing Address: P.O. Box 430 • West Covina, CA 91793
1050 Lakes Drive, Suite 120 • West Covina, CA 91790
Phone 626-646-1080 • Toll Free 877-516-0586 • Facsimile 626-931-1368
www.socalbrickmasonsbenefits.org • staff@socalbrickmasonsbenefits.org