U.A. LOCAL NO. 393 DEFINED CONTRIBUTION PLAN

I,_____, do hereby authorize the U.A. Local No. 393
(Participant's Name)

Defined Contribution Plan to make deductions and payments for premiums for coverage under the U.A. Local No. 393 Health and Welfare Plan for myself and my eligible dependents from my monthly benefit.

I understand that:

- The date the deduction will commence will be verified by the Fund Office
- The health and welfare self-pay rate deducted will be adjusted to reflect future rate changes.

This revocable authorization shall not confer upon the U.A. Local No. 393 Health and Welfare Plan any enforceable legal rights to collect any sums payable by the U.A. Local No. 393 Defined Contribution Plan to the undersigned as pension benefits.

_____	_____
Member Signature	Date
_____	_____
Member Name (Please Print)	Social Security Number
_____	_____
Phone Number	Email Address

Acknowledgment from Health and Welfare Department

Acknowledged by: _____