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—but, since hundreds of checks are issued from the Pension Fund each month via computer, such notice must be given at least sixty- (60) days in advance. If, however, you wish to end your coverage under the Health Care Fund for whatever reason, you may do so by notifying the Health Care Fund before the first day of the month you wish your coverage to stop. 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 Health Care Fund.

If, and when, the rates of self-payment are 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 Health Care Fund.

LABORERS' METOPOLITAN DETROIT
HEALTH CARE FUND

ASSIGNMENT AND AUTHORIZATION REQUEST

I, the undersigned, am receiving a monthly benefit from (Please check the Pension Fund that you receive your monthly pension from):

Laborers' Pension Trust Fund – Detroit & Vicinity

Michigan Laborers' Pension Fund

and am also maintaining my eligibility for benefits under the Laborers' Metropolitan Detroit Health Care Fund by means of self-payments. As a convenience to me and to assure my continued Health Care Fund eligibility, I hereby request and authorize you to deduct from my monthly Pension Fund Benefit whatever amounts may be required from time to time to maintain my coverage under the Health Care Fund as shall be reported to you by the Health Care Fund and to remit such deducted amounts directly to the Health Care Fund.

I understand that I may revoke this authorization at any time by notifying the Health Care Fund Office, in writing, at least sixty- (60) days before the effective date of the termination.

Participant's Name (Printed or typed) Member ID or SS Number

Spouse's Name (Printed or typed) Spouse's Social Security Number

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 Amount of Deduction

Effective Date Amount of Deduction