

## **REQUEST FOR INTERNATIONAL RECIPROCITY TRANSFER**

111 W CATALDO – PO BOX 5434  
SPOKANE WA 99205  
(509) 328-0300

Retirement and Health hours will not be transferred or accepted by transfer individually. In other words, if you wish your health hours to be transferred to another trust fund, your pension hours must be transferred as well, or vice versa.

### **INSTRUCTIONS FOR FILING REQUEST**

1. Complete the Transfer Request and Consent Form
2. Submit the Transfer Request and Consent Form to the Cooperating Fund.
3. After receipt of the request, the Cooperating Fund will determine if the request for such a transfer is appropriate in accordance with the provisions of the International Reciprocity Agreement.

**TRANSFER REQUEST AND CONSENT FORM**

**TYPE OR PRINT**

EMPLOYEE NAME: \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

EMPLOYEE ADDRESS: \_\_\_\_\_  
Street City St. Zip

EMPLOYEE TELEPHONE # \_\_\_\_\_ EMPLOYER NAME \_\_\_\_\_

TRANSFER HOURS/CONTRIBUTIONS EFFECTIVE \_\_\_\_\_  
MONTH YEAR

TRANSFER HOURS AND CONTRIBUTIONS FOR \_\_\_\_ HEALTH \_\_\_\_ PENSION

NAME OF COOPERATING FUND: \_\_\_\_\_

\_\_\_\_\_  
Address City St Zip

NAME OF HOME FUND: \_\_\_\_\_

\_\_\_\_\_  
Address City St Zip

I request contributions remitted to a Cooperating Fund by my employer be remitted to my Home Fund in accordance with the terms and conditions of the International Reciprocal Agreement for Carpenters, except as specifically modified herein.

I understand that contributions remitted more than 60 days prior to the commencement of my participation with the above mentioned Cooperating Fund are not transferable.

I understand this request for Transfer of Contributions must be filed within 60 days following the commencement of my employment within the jurisdiction of the Cooperating Fund.

I understand that I will no longer have a claim against the Cooperating Fund for any benefits which otherwise might accrue for myself, my dependents or my survivors, based upon such contributions. I also understand that my eligibility for any benefits based on such contributions will be determined solely in accordance with the Plan of Benefits of my Home Fund.

I understand that it is possible for benefits to be reduced or lost as a result of such a transfer, although I believe the transfer will be to my advantage. In order to induce the Funds to transfer contributions as I have requested, I waive, on behalf of myself and my dependents, heirs, beneficiaries and assigns, any claim for benefits which I or they may lose and to which I or they would have been entitled but for the transfer of contributions, and I agree to hold both Funds and the Trustees of both Funds serving from time to time harmless from and to indemnify them against any and all payments, including legal fees and costs, which they incur in connection with such claim.

I understand that I may cancel this request at any time by giving you written notice of such cancellation.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_