trust fund office
local union 831
employer health trust fund
employer pension plan
P.O. Box 3118, Covina, California 91722-9118
Toll Free (877) 572-7005 · Phone (626) 279-3080 · Fax (626) 279-3055

**Request for Transfer of Hours and Contributions (Health and Welfare) to my Home Trust**

I am a participant of the Local Union 831 Employer Health Trust Fund ("Home Trust") where my Health and Welfare contributions are normally made.

I will be working for _____,

in the county of _____, Local _____.

I hereby request to have the cooperating Trust _____ transfer to my Home Trust my Health and Welfare hours and contributions made on my behalf. My request shall be applied for the hours I worked beginning with the following work month:

Work Month: _____ Year: _____

**Authorization shall be effective for a period of six months**

_____ _____
Print Employee's Full Name Employee's Signature

_____ _____
Employee's Social Security Number Employee's Phone Number

_____
Employee's Permanent Street Address City State Zip Code

**Witnessed by:**

_____ _____
Signature Date

Please return the completed form to the cooperating Trust within 60 days of the contractor's contribution due date. The completion of this form may be witnessed by your Contractor, Business Representative or Trust Representative.

| **Remit to:** | **Payable to:** |
|---|---|
| Local Union 831 - Employer Health Trust Fund<br>Attn: Reciprocity<br>P.O. Box 3118<br>Covina, CA 91722-9118<br>employerbilling@pswadmin.com<br>(626) 279-3072 | Local Union 831- Employer Health Trust Fund |