MEMBER'S NAME: _____ **SSN:** _____

AUTOMATIC DEDUCTION FORM

LDC&C Pension Fund of Ohio Assignment of Pension Benefits to OLDC-OCA Insurance Fund

(Please complete this form and submit it to Ohio Laborers Benefits to have your monthly Retiree Insurance Premium for the OLDC-OCA Insurance Fund deducted from your monthly Pension Benefit from the LDC&C Pension Fund of Ohio.)

In order to facilitate payment of premiums due from me to the Ohio Laborers' District Council-Ohio Contractors' Association Insurance Fund for continuous coverage under the Insurance Fund for me (and, whenever appropriate, for certain other individuals represented to the Insurance Fund by me as being my eligible dependents), I hereby assign to the Insurance Fund such portion of the monthly pension benefit currently being paid to me by the Laborers' District Council and Contractors' Pension Fund of Ohio as may be necessary to pay said premium in advance of the month or months for which such coverage is to be provided by the Insurance Fund. I understand that my monthly pension benefit will be reduced by the amount payable by me for each month such coverage is provided by the Insurance Fund and that the amount so assigned may be changed without notice to me to reflect any change in the premium charged by the Insurance Fund to provide the coverage in question. Payment of the amount so assigned will be made by the Pension Fund directly to the Insurance Fund at the time the remaining balance, if any, of my monthly pension benefit is paid to me.

I understand this monthly assignment is fully intended to comply with Treasury department regulation Section 1.401(a)-13(e) regarding exceptions to the general rule under Section 401 (a)(13) of the Internal Revenue Code of 1954, as amended, against assignment or alienation of benefits payable out of a pension plan and trust qualified and exempt under Sections 401(a) and 501(a) respectively of the Code. I understand that this monthly assignment is voluntary by me and may be revoked by me at any time. I understand that, should I revoke this monthly assignment, payment of the required monthly premium to the Insurance Fund to assure continuous coverage thereunder is solely my responsibility.

Member's Signature: _____ **Date:** _____

INSURANCE FUND – BENEFICIARY DESIGNATION FOR DEATH BENEFITS

Please refer to the Insurance SPD (available at ohiolaborers.com) for rules regarding beneficiary designation.

Primary Beneficiary *(You may list one or multiple Primary Beneficiaries in the space below.)*

Full Name(s): _____ SSN: _____

Full Address(es): _____

Date of Birth(s): _____ Relationship(s): _____

Secondary Beneficiary *(You may list one or multiple Secondary Beneficiaries in the space below. Your Secondary Beneficiary will only receive benefits if your Primary Beneficiary is deceased at the time of your death.)*

Full Name(s): _____ SSN: _____

Full Address(es): _____

Date of Birth(s): _____ Relationship(s): _____

Member's Signature: _____ **Date:** _____