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; however, such notice must be given at least sixty- (60) days in advance. If, for some reason, you wish to end your coverage under the Health Care Plan, you may do so by notifying the Health Care Plan the first day of the month you wish your coverage to end. 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 Plan.

Should the rate of self-payment be 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 Plan.

SHEET METAL WORKERS LOCAL UNION NO. 7, ZONE 2 FRINGE BENEFIT FUNDS

Sheet Metal Workers Local Union No. 7, Zone 2 Health Care Plan — Managed for the Trustees by:
Sheet Metal Workers Local Union No. 7, Zone 2 Pension Plan — TIC INTERNATIONAL CORPORATION

ASSIGNMENT AND AUTHORIZATION REQUEST

TO: Board of Trustees
Sheet Metal Workers Local Union No. 7, Zone 2 Pension Plan

I, the undersigned, am receiving a monthly benefit from the Sheet Metal Workers Local Union No. 7, Zone 2 Pension Plan and am also maintaining my eligibility for benefits under the Sheet Metal Workers Local Union No. 7, Zone 2 Health Care Plan by means of self-payments. As a convenience to me and to assure my continued Health Care Plan eligibility, I hereby request and authorize you to deduct from my monthly Pension Plan Benefit whatever amounts may be required from time to time to maintain my coverage under the Health Care Plan as shall be reported to you by the Health Care Plan and to remit such deducted amounts directly to the Health Care Plan.

I understand that I may revoke this authorization at any time by written notice to you, but also understand that at least sixty- (60) days advance notice to do so is required.

_____ _____
Name (Printed or typed) 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 Plan.

SEE EXPLANATION ON BACK OF THIS FORM

THE FOLLOWING IS TO BE COMPLETED BY THE SHEET METAL WORKERS HEALTH CARE PLAN FUND OFFICE:

_____ _____ _____
Amount Effective Date Fund Office Signature and Date