SMART MEMBER TRAVELING INFORMATION SHEET

TRAVELER INFORMATION

Full Legal Name: _____ Member IA Number: _____

Date of Birth: _____ SSN: _____ Dues Paid-Through Date: _____

Cell Phone: _____ Email Address: _____

Street: _____ City: _____ State: ____ Zip: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

HOME Local Union with Region/Zone/Area: _____ Home Local Phone: _____

☐ Yes ☐ No Health & Welfare: _____

☐ Yes ☐ No 401k/Annuity: _____

☐ Yes ☐ No Local Pension: _____

☐ Yes ☐ No National Pension: _____

☐ Yes ☐ No SASMI: _____

DESTINATION Local Union with Region/Zone/Area: _____ Destination Local Phone: _____

Destination Local Union Contact Person: _____ Cell Phone: _____

Contractor: _____ Onsite Contact: _____ Cell Phone: _____

Jobsite: _____

Location: _____

Start Date: _____ End Date (if known): _____

ADDITIONAL INFORMATION: Must carry Photo ID, Current Official Dues Receipt, and any other information specified by Destination Local.

Is this a JOB BANK Request? ☐ Yes ☐ No

Is SASMI Guaranteeing 30 days? ☐ Yes ☐ No

Is there a SMART Travel Incentive? ☐ Yes ☐ No Amount: _____

Is Contractor Offering Per Diem? ☐ Yes ☐ No Amount: _____

Is Destination Local Offering Per Diem? ☐ Yes ☐ No Amount: _____

HEALTH AND WELFARE FUND RECIPROCAL AGREEMENT / AUTHORIZATION TO TRANSFER CONTRIBUTIONS

Full Legal Name: _____ **Member IA Number:** _____

Date of Birth: _____ **SSN:** _____ **Cell Phone:** _____

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Local: _____

I am temporarily working in the jurisdiction of: _____

I hereby elect, to the extent that the Trustees of the Cooperating Fund and the Trustees of my Home Health and Welfare Fund have executed agreements between them permitting the transfer of contributions, to have Health and Welfare Fund contributions paid on my behalf to the Cooperating Fund remitted to my Home Health and Welfare Fund**.** I understand that the Cooperating Fund will act solely as the agent of the noted Home Fund and as such, I shall be subject to the eligibility rules of said Home Fund upon the transfer of contributions. I hereby release (on behalf of myself as well as on behalf of anyone claiming through me) and further discharge the Cooperating Fund and its Trustees of and from all claims, demands, actions, causes of actions or suits with respect to any contributions so transferred and for any benefits or credits which would have accrued or become payable to me had I not authorized this transfer of contributions. I further recognize that the transfer of contributions to the noted Home Fund may or may not ultimately prove to be to the advantage of myself and/or my beneficiaries.

_____ _____

DATE SIGNED **SIGNATURE**

401K AND/OR ANNUITY FUND RECIPROCAL AGREEMENT / AUTHORIZATION TO TRANSFER CONTRIBUTIONS

Full Legal Name: _____ **Member IA Number:** _____

Date of Birth: _____ **SSN:** _____ **Cell Phone:** _____

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Local: _____

I am temporarily working in the jurisdiction of: _____

I understand that the Cooperating Fund will act solely as the agent of my Home Fund and as such, I shall be subject to the eligibility rules of said Home Fund upon the transfer of contributions. I hereby release (on behalf of myself as well as on behalf of anyone claiming through me) and further discharge the Cooperating Fund and its Trustees of and from all claims, demands, actions, causes or actions or suits with respect to any contributions so transferred and for any benefits or credits which would have accrued or become payable to me had I not authorized this transfer of contributions.

_____ _____

DATE SIGNED **SIGNATURE**

PENSION FUND RECIPROCAL AGREEMENT / AUTHORIZATION TO TRANSFER CONTRIBUTIONS

SMW National Pension Fund, 3180 Fairview Park Dr. Ste 400, Falls Church, VA 22042,
Tina Winske, (703)739-7097, twinske@smwnbf.org

Full Legal Name: _____ **Member IA Number:** _____

Date of Birth: _____ **SSN:** _____ **Cell Phone:** _____

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Local: _____

I am temporarily working in the jurisdiction of: _____

I understand that the Cooperating Fund will act solely as the agent of my Home Fund and as such, I shall be subject to the eligibility rules of said Home Fund upon the transfer of contributions. I hereby release (on behalf of myself as well as on behalf of anyone claiming through me) and further discharge the Cooperating Fund and its Trustees of and from all claims, demands, actions, causes or actions or suits with respect to any contributions so transferred and for any benefits or credits which would have accrued or become payable to me had I not authorized this transfer of contributions.

_____ _____

DATE SIGNED **SIGNATURE**

_____ **WORKING ASSESSMENT FUND AUTHORIZATION**

Full Legal Name: _____ **Member IA Number:** _____

Date of Birth: _____ **SSN:** _____ **Cell Phone:** _____

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Local: _____

I am temporarily working in the jurisdiction of: _____

I hereby, of my own free will an accord, authorize my Employer to deduct from my wages the assessment for each hour worked approved by the members of Destination Local Union for _____ Fund, and to forward said sum every month together with a summary of the hours worked during the month to the officer of the Administrator of the Funds. This voluntary authorization shall be irrevocable for a period of one (1) year or until the termination date of the Agreement between the Local Union and the Employer, whichever occurs sooner, and shall be automatically renewed, and shall be irrevocable for successive periods of one (1) year each, or for the period of each succeeding applicable Agreement between the Local Union and the Employer, whichever occurs sooner, unless written notice is given by mail to the Local Union and the Employer not less than ten (10) days prior to the expiration of each period of one (1) year or of each applicable Agreement, whichever occurs sooner.

_____ _____

DATE SIGNED **SIGNATURE**