



**Southern Operators Health Fund**  
**P.O. Box 1449**  
**Goodlettsville, TN 37070-1449**  
**Phone: 800-831-4914 Fax: 615-855-6105**

**Reciprocal Request Notification**

**(Must be completed in its entirety)**

**Participant Information**

<b>Social Security Number</b>	
<b>Name</b>	
<b>Street Address</b>	
<b>City, State, Zip Code</b>	
<b>Phone Number</b>	

**Home Fund Information**

<b>Home Local Union Number</b>	
<b>Name of Home Health Fund</b>	

**Cooperating Outside Fund Information (local where work was performed outside your home local)**

<b>Outside Local Union Number</b>	
<b>Name of Outside Health Fund</b>	

**I hereby elect to have contributions paid on my behalf to the Cooperating Outside Fund(s) sent to my Home Fund(s). This authorization shall continue until revoked by me in writing and delivered to the Home Fund(s) and the Outside Fund(s).**

**Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_**