OPERATING ENGINEERS VACATION-HOLIDAY SAVINGS TRUST

P. O. BOX 7064, PASADENA, CA 91109
PHONE (626) 356-1050; FAX **(626) 356-3502**

APPLICATION FOR WITHDRAWAL OF BENEFITS

INSTRUCTIONS: Complete this form and return it to the Fund Office at the above address. The application will be processed and your check will be mailed directly to you.

Participant Information:

Name_____ Social Security Number_____

Mailing Address_____ Phone Number (____)_____
STREET

_____
CITY STATE ZIP

Withdrawal Information:

I would like to withdraw _____ from contributions on deposits for work between
(AMOUNT OR PERCENTAGE)

July, 20_____ and June, 20_____.

The participant understands that a withdrawal from the participant's account for any Plan Year will disqualify the participant from receiving any distribution of reserves which accumulated partially or entirely during that Plan year. Each withdrawal may not reduce the amount deposited in the account to less than $10.00.

Date _____ Signature _____

Witnessed by _____
(PRINT NAME) (SIGNATURE)

IF APPLICATION IS NOT WITNESSED BY A REPRESENTATIVE OF LOCAL 12 OR FUND OFFICE, IT MUST BE NOTARIZED:

State of _____ }
County of _____ }

On _____ before me, _____,
DATE NAME, TITLE OF OFFICER-E.G. "JANE DOE, NOTARY PUBLIC"

personally appeared _____,
NAME(S) OF SIGNER(S)

( ) personally known to me - **OR**
( ) proved to me on the basis of satisfactory evidence to be the person (s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature (s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

_____
SIGNATURE OF NOTARY

FOR OFFICE USE ONLY

Date of Application _____ PYE June, 20_____

Hours _____ Amt. Paid_____ Withdrawal Amt._____ Ck No. _____

Receipt of Withdrawal amount is acknowledged_____
SIGNATURE