

IBEW LOCAL UNION 697 SUB FUND

BENEFIT BALANCE CHANGE

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

In accordance with the provisions of the IBEW Local Union 697 SUB Fund Trust Agreement, I hereby request the option to change my SUB Fund Benefit Balance to the amount of:

<input type="checkbox"/>	\$2,000.00
<input type="checkbox"/>	\$4,000.00
<input type="checkbox"/>	\$6,000.00
<input type="checkbox"/>	\$8,000.00

(Please initial one box)

This request will be effective for hours worked in the month this form is received by the Fund Office. For example: If we receive this form in August it will take effect for hours worked in August.

This amount will remain in effect until a new form is filled out and received by the Fund Office. I understand that I cannot request a lower level until my SUB Fund Benefit Balance is below the level requested.

Signature: _____

SSN: _____

Date: _____

**Return completed form to:
7200 Mississippi Street, Suite 300, Merrillville, IN 46410
Phone: (219) 845-4433 or (219) 940-6181**