

EMPLOYER ADJUSTMENT FORM

**International Union of Operating Engineers, Local No. 4
Health & Welfare, Pension, and Annuity Funds**

16 Trotter Drive
P.O. Box 680
Medway, MA 02053-0680
Phone: (508) 533-1400
(888) 486-3524
Fax: (508) 533-1425
www.local4funds.org

Please use these forms if you need to make corrections to a previously submitted remittance report. Please attach this form with a corrected report as applicable (see following pages). If you have any questions, please contact our Employer Reporting Help Desk 1-508-533-1400 x 302.

PLEASE CHECK ALL THAT APPLY:

Employer Account Number _____

- Incorrect rates were used
- Incorrect Hours reported
- Incorrect Wages reported
- Incorrect Dues/SAC reported
- Incorrect 401(k) reported
- Additional hours, wages, dues, SAC, or 401(k) that need to be reported
- Incorrect month reported for, should have been reported for _____
- Incorrect Account# used, reported under _____, should have been for Account# _____
- Incorrect member/social security number reported
- Other:
- This is the final report Month/Year _____
- Member belongs to another Operating Engineers Local # _____
- Please check this box for address change, and list your account# and new address:



International Union Operating Engineers, Local No.4
Health, Welfare, Pension and Annuity Funds
 16 Trotter Drive, P. O. Box 680
 Medway, MA 02053-0680
 Phone: (508) 533-1400
 FAX: (508) 533-1425

Employer:
Address:

Report Month/Year

Final Report: YES _____ NO _____

Total Hours: _____ **OT Hours:** _____

Gross Wages: _____ **# Employees** _____

Job Name: _____

Employer #:

Billing Location:

FUND	RATE	AMOUNT DUE
1. H&W		_____
2. Pension		_____
3. Apprent/Trn		_____
4. Annuity Tot.		_____
5. Annuity OT		_____
6. Coop Trust		_____
7. NTF		_____
8. Subtotal (#1 - #7)		_____
9. Interest Due		_____
10. Subtotal #8 + #9		_____
--- Employee Deductions---		
11. Dues		_____
12. S.A.C		_____
13. 401K Plan		_____
14. Total Adjustments		_____
Total due #10 - #14		_____

Less Award: \$ _____

Your Check Amount: \$ _____

Total Due: \$ _____

Check Number: _____

The undersigned verifies under penalties of perjury that this report is complete and accurate as to all covered employees for the relevant time period.

Print Name and Title: _____

Date: _____

Signed: _____

Payments not received at the Fund Office by the last day of the month following the month during which the work was performed will be assessed interest at the rate of one (1%) percent per month, except that interest due on late Annuity and Savings Plan 401(k) payments shall be assessed in accordance with the rules and regulations of the Department of Labor.

Benefits ID	Name	Local#	Total Hours	OT Hours	Gross Wages	Dues	SAC	401K
Total Members #		TOTALS:						

CURRENT PERIOD ADDS / ADJUSTMENTS:

Benefits ID	Date of Birth							
Name		Address: City, State, Zip						
Benefits ID	Date of Birth							
Name		Address: City, State, Zip						
Benefits ID	Date of Birth							
Name		Address: City, State, Zip						
Benefits ID	Date of Birth							
Name		Address: City, State, Zip						