

**GMR Associates Employee Benefit Trust
Monthly Statement Electronic Waiver**

Name: _____

Employer's Name: _____

Last 4 Digits of SSN: _____

Monthly Benefit Statement:

☐ I wish to opt out of receiving **AND** accessing my monthly trust benefit statement electronically. Please send via USPS at my address on file.

NOTE: Statements are only generated if the criteria set by your employer are met. GMR cannot track or control delivery through the USPS once it has left our office.

You must sign and date this form below. Once this form is received by GMR, we will implement this change. GMR reserves the right to change its distribution policy at any time.

Employee Signature

Date

**Return form to: GMR Associates, Inc.
 P.O. Box 24369
 Rochester, NY 14624
 Attn: Operations**

OR

Fax to: 585-426-6981