

UFCW Health and Welfare Fund of Northeastern Pennsylvania

DISABILITY BENEFIT DIRECT DEPOSIT AUTHORIZATION FORM

This form must be completed if you elect to receive your Disability Benefit payment(s) via direct deposit.

Dear Participant:

Participants of the UFCW Health and Welfare Fund of Northeastern Pennsylvania who receive disability benefits may elect to receive their payments via direct deposit into a bank account.

Therefore, please fill in the form below with the requested information:

Participant Name: _____
Please Print

Participant SSN: _____

Bank Name: _____

Bank Address: _____
Street

_____ City State Zip Code

Routing/Transit Number: _____

Bank Account Number: _____

*****CALL YOUR BANK IF YOU NEED HELP WITH ROUTING AND/OR ACCOUNT INFORMATION*****

Check one: **Checking Account (ATTACH A VOIDED CHECK)** **Savings Account**

By completing this form, I elect to have my Disability Benefit payments deposited directly into my bank account. I authorize my bank to make appropriate adjustments if an incorrect amount is ever entered into my account.

DATE

PARTICIPANT SIGNATURE

*****This form must be completed and returned to the Fund Office*****