Retiree Health Benefit Plan

417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
Tel. (212) 580-9092 or (800) 456-3863
Fax (646) 783-7650 /Email to psc@iatsenbf.org

AUTHORIZATION AGREEMENT FOR ELECTRONIC TRANSFER

Name: ____ SSN:_______________________ID# ________________

Address: ____

City: ____ State: __________ Zip Code _________________

Phone: (______) ________________________ Email Address: ____

I hereby authorize the I.A.T.S.E. Retiree Health Benefit Plan, to initiate credit and debit entries in connection with the distribution to my account as designated below at the financial institution (the "Depository") named below and to credit or debit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with all applicable provisions of U.S. law.

Bank Name: ____

Phone: (______) ____________________________

Account Type (check one): ☐ Checking ☐ Savings

Account Number: ________________________________

9 Digit ACH Routing Number

(Ask your bank to furnish the routing # or send us a VOIDED check for your account)

This authorization is to remain in full force and effect until the Fund has received written notification from me of it termination in such time and in such manner as to afford the Fund and the Depository a reasonable opportunity to act on it.

Signature of Plan Participant ____________________________________ Date _________________________________