



DIRECT DEPOSIT AUTHORIZATION

Participant Name:			
Social Security Number:			
Address:			
City:	State:	Zip:	
Authorizing direct deposit for the following funds (circle all that apply):			
SUB	HRA	Pension	Loss of Time
Banking Information			
Name of Bank:			
Routing Number:			
Account Number:			
Checking		Savings	

I hereby authorize the Electrical Workers Benefit Trust Fund to deposit benefit payment to the account and bank or financial institution identified below and authorize the bank or financial institute to accept these deposits.

This Authorization is to remain in full force and effect until the Fund has received written notification of its termination from me at such time and in such manner as to afford the EWBTF a reasonable opportunity to act on it. If benefits to which I am not entitled are deposited to my account I authorize the Fund to direct the bank or financial institution to return the full amount of said benefit immediately.

I agree that these deposits and adjustments, if any, may be made electronically and under the Rules of the Indiana Automated Clearing House Association (ACH).

Signature:	Date:
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