# 1199SEIU Benefit and Pension Funds

498 Seventh Avenue • New York, NY 10018-0009 • Tel: (646) 473-6710 • Fax: (646) 473-6768 • www.1199SEIUBenefits.org

## Direct Electronic Deposit Authorization for Disability Benefits

(Please allow a minimum of two (2) weeks for this authorization to be processed.)

Please note that a new authorization is required for each new (unique) disability claim.

Please print clearly in black or blue ink, or complete online. **Remember to sign and date this form or it will not be valid.**

MEMBER'S FULL NAME _____ MEMBER ID # _____

MEMBER'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MEMBER'S PREFERRED PHONE _____ MEMBER'S SOCIAL SECURITY # _____

**Election of Direct Deposit – you must sign and date this form to make <u>any</u> change *(choose one)*:**

- ☐ New disability benefits direct deposit
- ☐ Change from my current financial institution to the financial institution listed below
- ☐ I am staying with my financial institution, but my account information has changed
- ☐ Cancel my direct deposit and send my checks to my home address listed above

**For direct deposit into a checking account:** Requires a voided check with the account holder's name pre-printed on the check; a stamp from the financial institution on this form; or a signed letter from the financial institution on company letterhead confirming the account holder, routing number and account number.

**For direct deposit into a savings account:** Requires a stamp from the financial institution on this form or a signed letter from the financial institution on company letterhead confirming the account holder, routing number and account number.

**For banks in foreign countries or banks that do not accept direct deposit:** Your check will be mailed directly to your home address.

**Fill out this section to begin or change your direct deposit. If you are canceling your direct deposit, leave this section blank.**

Type of account ***(choose one):*** ☐ Savings ☐ Checking _____ EFFECTIVE DATE (MM/DD/YYYY)

ROUTING # **(9 DIGITS)** _____ ACCOUNT # _____

NAME OF FINANCIAL INSTITUTION _____

ADDRESS OF FINANCIAL INSTITUTION _____ CITY _____ STATE _____ ZIP CODE _____

**X** _____
FINANCIAL INSTITUTION'S AUTHORIZING SIGNATURE **(REQUIRED)**

**Financial Institution Stamp Below**

Until further written notice from me, I hereby authorize the 1199SEIU Benefit and Pension Funds ("the Funds") to: (a) deposit my disability payment amount in my account, chosen above; and (b) make adjustments and have my account charged for any erroneous credits or other amounts to which I am not entitled. I further understand that should I close or change this account, I must give a new completed form to the Disability Department at least two (2) weeks before the disability direct deposit is to be terminated. I understand that direct deposit is a completely voluntary service provided by the Funds for my convenience, and that it can be terminated by the Funds or by me at any time. Because the wrong number can lead to my disability payment being sent to the wrong person's account, I understand that I must ensure my account type, account number and routing number are all correct.

**X** _____
MEMBER'S SIGNATURE **(REQUIRED)** DATE (MM/DD/YYYY) **(REQUIRED)**

3NBF343B • 03/21 • ELECTRONIC DEPOSIT AUTHORIZATION