ELECTRONIC DIRECT DEPOSIT FORM

[(√) Check Appropriate Box]

AUTHORIZATION FOR ELECTRONIC PAYMENT SERVICE: ☐ New Direct Deposit ☐ Change of Financial Institution ☐ Change of Account #

↓ Name of Financial Institution | Account Number | Routing Number

☐ Checking *or* ☐ Savings

(If you are using a checking account please submit a voided check)

↓ Member's Name (Please Print) | ↓ Member Social Security Number

↓ New Address (*if applicable*) | Apt. # | City | State | Zip

↓ New Phone Number (*if applicable*)

I authorize the Pension Fund for Hospital and Health Care Employees - Philadelphia and Vicinity, hereafter referred to as COMPANY, to deposit my periodic pay into my account identified as and held at the FINANCIAL INSTITUTION named above, and I authorize that such account exists and that the FINANCIAL INSTITUTION can make deposits without responsibility for correctness of such amounts. My authorization will remain in effect until I give a written notice to terminate this authorization to the COMPANY in sufficient time and manner as to allow the COMPANY to act upon it. In addition, either the COMPANY or the FINANCIAL INSTITUTION can terminate this agreement by providing me with their written notice at least 10 days prior to actual termination.
I have provided the COMPANY with a copy of a voided check solely for the purposes of verifying my account number and the FINANCIAL INSTITUTION'S transit number.

Date _____ Member's Signature _____

Date _____ Bank Representative's Signature _____

Note: *You are responsible for providing the Pension Fund with current changes to your account and/or address in a timely manner. If timely notification is not received; it may result in a delay in you receiving your monthly pension check. All bank changes will have to be submitted by the 16th of each month. If not, changes will be made for the following month.*