MCASF Local 725 Health & Welfare Trust Fund

Loss of Time (Short-Term Disability) Benefit

15800 Pines Blvd., Suite 201 Pembroke Pines, FL 33027
Phone (754) 777-7735 Fax (754) 999-2205

Direct Deposit

The BEST way to receive your weekly disability benefit

And here's why…

Direct deposit is ***safe*** because your benefit payment is automatically deposited into your bank account – no more worrying about lost or stolen checks or delays caused by mail service.

Direct deposit is ***fast*** because no matter if you are sick or away from home, your check is still deposited into your account. No more standing in long bank lines or waiting for your check to clear.

Direct deposit is ***easy*** because your benefit payment is deposited into your checking or savings account on time, correctly and confidentially.

Please take a few minutes and complete the form on the back so you can take advantage of the benefits of Direct Deposit. It will take the Fund Office about 30 days after it receives your authorization to set up the procedure with your bank. Please be assured there will be no interruption in your monthly benefit and there is no cost to you.

*****IMPORTANT*****

Please notify the Fund Office *immediately* whenever you change your address so that our records will be updated, and you will continue to receive your monthly direct deposit.

MCASF Local 725 Health & Welfare Trust Fund
DIRECT DEPOSIT AGREEMENT

Name of Payee_____Social Security No _____

Address _____

City_____State_____Zip_____

Telephone No ( ) _____

Bank Account Information *– Attach a voided check from your account and/or complete the information below. See sample check at the bottom of the page for help completing this section.*

Routing No._____ Account No._____

Type of Account: ☐ Checking ☐ Savings

Financial Institution

Name _ _____

Address_____

City_____State_____Zip_____

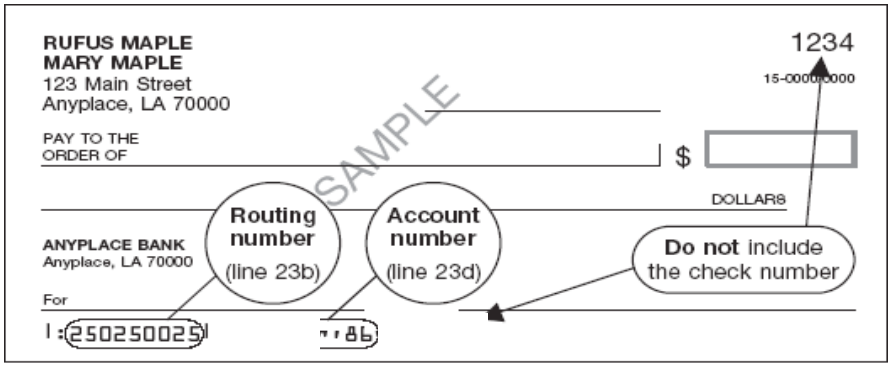
Telephone Number _ _____

Please allow up to 30 days for the direct deposit set-up process to be completed.

I, the undersigned, hereby authorize the Board of Trustees of the Health & Welfare Trust Fund ("the Health Fund") to deposit all amounts due to me under the Loss of Time Benefit provision in my account at the Financial Institution named above. This authorization shall remain in force until I revoke it in writing or until my death, whichever occurs first. If at any time the Health Fund should credit my account for a benefit to which I am not entitled, I authorize and direct the Financial Institution to refund the Health Fund.

_____ _____

Payee Signature Date



Note: *The routing and account numbers may be in different places on your check.*