EFT Direct Deposit Authorization
(PLEASE PRINT LEGIBLY OR TYPE)

Plan Name: IAFF Local 587 Health Insurance Trust Fund

Name: _____ Last 4 of SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

I authorize IAFF Local 587 Health Insurance Trust Fund to initiate Direct Deposits (credit entries) to my financial institution account indicated below. This authorization will remain in full force and effect until I notify the Trust in writing to change or cancel the authorization. Any changes to this authorization must be received by the Trust no later than the 12th of the month to take effect on the 1st of the following month. All new account information will be pre-noted before the change will take effect; therefore, you may receive a paper check for one month before the new account information is verified and processed. I have verified my address on file to avoid any delay in processing distributions. I have also attached a VOID check for the deposit account (**Starter checks are not acceptable**).

I authorize the IAFF Local 587 Health Insurance Trust Fund to recover money deposited electronically in my account in error, either by adjusting the account or withholding any future payments. I understand that I will be notified by the ***Trust*** before adjustments are made. I have notified any joint account holder(s) of the obligation to repay any overpayment to this account after my death if the overpayment is not repaid by the financial institution.

_____ _____

(Member Signature - *MUST BE SIGNED IN PRESENCE OF A NOTARY*) (Date)

A. CHECKING:

Institution: _____ Branch: _____
City: _____ State: _____
Routing/ABA No: _____ Account No: _____

B. SAVINGS:

Institution: _____ Branch: _____
City: _____ State: _____
Routing/ABA No: _____ Account No: _____

Please Attach a "VOID" Check or Letter from Your Financial Institution or Account

Requests will not be processed without a VOID check or a letter from the financial institution or bank. The check or typed confirmation from the financial institution MUST have the following information: checking or savings account number, bank routing number, and the account owner(s) name. Starter checks are not acceptable.

STATE OF: _____

COUNTY OF: _____

BEFORE ME, the undersigned authority, appeared before me _____ by means of physical presence

□ online notarization and who is □ personally known to me or □ has produced _____ as identification,

and who did take an oath and, after being duly cautioned and sworn, deposes and says that he/ she has signed the foregoing

document for the reasons therein contained.

SWORN TO AND SUBSCRIBED before me this the _____ day of _____, _____.

_____

Notary Public Signature

(Notary Seal)

_____

Notary Public Printed Name

My Commission Expires: _____

My Commission Number Is: _____

Return Completed Form to:

IAFF Local 587 Health Insurance Trust Fund
2980 NW South River Drive
Miami, FL 33125-1146
Phone 305-425-1938
Fax 305-633-3935
bookkeeper@healthtrustmaff.org