

**AUTHORIZATION FOR AUTOMATED DIRECT DEPOSITS**

I hereby authorize Teamsters Local 641 Pension Fund to initiate credit entries and to initiate, if necessary, debits and adjustments for any credit entries made in error to the account listed below. This authorization is not given to carry into effect an assignment of benefits to anyone of my rights to receive my pension payments. This authorization is to remain in full force and effect until Teamsters Local 641 Pension Fund has received signed, written notification from me of its termination in such time and in such manner as to afford the Fund a reasonable opportunity to act on it. I promise to notify the Fund of any changes to the account. I understand that Teamsters Local 641 Pension Fund may pay benefits only to an individual and that my receipt of benefits will be deemed income to me.

PARTICIPANT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
# & STREET CITY STATE ZIP

SOCIAL SECURITY #: \_\_\_\_\_ PHONE #: \_\_\_\_\_

**YOUR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

CHECK **ONE BOX ONLY** - (EITHER CHECKING **OR** SAVINGS!) & COMPLETE THE SECTION OF THIS FORM FOR THE TYPE OF ACCOUNT YOU ARE USING!

**CHECKING ACCOUNT** OR  **SAVINGS ACCOUNT**

Tape or attach check here  
Please attach a voided/cancelled check for the checking account into which you want your payment directly deposited.

**NO STARTER CHECKS/NO ACCOUNTS WITHOUT THE PENSION RECIPIENT'S NAME ON THE CHECK.**

**PLEASE NOTE THAT THE 1<sup>st</sup> MONTH FOLLOWING A DIRECT DEPOSIT REQUEST, THE PENSION CHECK MAY BE SENT TO YOUR HOME. AS OF THE 2<sup>nd</sup> MONTH, ALL BENEFITS WILL BE SENT TO THE BANK ACCOUNT CHOSEN ABOVE UNTIL WE ARE NOTIFIED OF A CHANGE.**

SAVINGS ACCOUNT BANK'S NAME: \_\_\_\_\_

BANK'S ROUTING #: \_\_\_\_\_ ACCOUNT #: \_\_\_\_\_

**\*Statement of Joint Account Holders\* To Be Completed If Yours Is A Joint Account Only!!**

This is to certify that I hold the above account jointly with the above named Benefit Recipient. I promise to notify Teamsters Local 641 Pension Fund in the event of death or incapacity of the Benefit Recipient. I authorize the Fund to initiate debits of any credit entries made after the death or incapacity of the Benefit Recipient. I further agree to return personally to the Fund any amounts that are not returned to the Fund through the initiation of debits to the account after the Benefit Recipient's death or incapacity.

**PRINT JOINT ACCOUNT HOLDER NAME(S):**

1. \_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF JOINT ACCOUNT HOLDER**

\_\_\_\_\_  
**SIGNATURE OF JOINT ACCOUNT HOLDER**