AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS

IBEW Local 234 Health and Welfare Plan:

I (we) hereby authorize IBEW Local 234 Health and Welfare Plan, herein called the Plan, to initiate debit entries to my (our) checking account / savings account at the Financial Institution named below, and to debit the same to such account. I (we) acknowledge that the origination of the automated clearing house transactions to my (our) account must comply with the provision of U.S. Law.

Please select one:

☐ Checking Account

☐ Savings Account

Financial Institution

Name _____ Branch _____

City _____ State _____ Zip _____

Routing Number _____ Account Number _____

This authorization is to remain in full force and effect until the Fund has received written notification from me of its termination in such time and in such manner as to afford the Trust and my referenced Financial Institution to act on it.

_____ _____

Name (Please Print) Spouse's Name (Please Print)

_____ _____

Signature Signature

_____ _____

Date Date

PLEASE ATTACH A VOIDED CHECK