IBEW 292 BENEFITS

6700 W. Broadway Ave., Ste B, Brooklyn Park, MN 55428
(763) 493-8830 (800) 368-9045 Fax (763) 416-6196 IBEW292benefits.org

I.B.E.W 292 HEALTH CARE PLAN
LOSS OF TIME BENEFIT
DIRECT DEPOSIT AUTHORIZATION FORM

MEMBER NAME | **MEMBER PHONE NUMBER** | **SOCIAL SECURITY NUMBER**

MAILING ADDRESS

CITY | **STATE** | **ZIP CODE**

BANK NAME | **TYPE OF ACCOUNT (CHECKING OR SAVINGS)**

BANK ADDRESS

CITY | **STATE** | **ZIP CODE**

ROUTING NUMBER | **ACCOUNT NUMBER**

I certify that the above account information is accurate. I request that my benefit payments be electronically transferred to my individual or joint account. This agreement remains in effect until I give written notice of cancellation to the I.B.E.W 292 HEALTH CARE PLAN or upon my death or legal incapacity. I have directed the financial institution to refund the Plan of any money transferred in error, upon notice from the Plan. I have notified any joint account holders 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 | **DATE**

Form can be mailed or dropped off at the IBEW 292 Benefits Office at 6700 W. Broadway Ave., Ste B, Brooklyn Park, MN 55428
Emailed to claiminfo@ibew292benefits.com or Faxed to 763-416-6196

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