



IBEW Local 234 Health & Welfare Plan



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 Account
 Number _____ 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