

Use this form to start or change direct deposit of your pension and/or medicare benefit. Be sure to cancel an existing direct deposit before making a change.

HRSA-ILA

Pension or Medicare Direct Deposit Form

Port No: _____ SS #: _____

Participant Name: _____

Participant E-Mail Address: _____

I authorize HRSA-ILA and the financial institution listed below to credit automatically to the indicated deposit account my:

- Monthly Pension benefit
 Quarterly Medicare premium reimbursement
(Check all that apply)

payable to me by the appropriate fund. If amounts to which I am not entitled are deposited to my account, I authorize HRSA-ILA Funds to direct the financial institution to return said amounts. This authority is to remain in effect until canceled in writing.

Financial Institution: _____

City: _____ State: _____ Zip: _____

Attach a voided check **here** or have your financial institution complete the transit routing/account numbers and place their **stamp** in the space provided.

Bank Stamp:

Transit Routing # _____

Account # _____

- **Direct deposit request will not be accepted without either a check or bank stamp**
- Starter checks for direct deposit will not be accepted
- Direct deposit will not be accepted unless the payee is the account holder or joint account holder
- Do not attach a deposit slip

Participant Signature: _____

Date: _____

Form D-1
Revision Date May 1, 2010