Elections received later than 1 week before a benefit payment date can not be implemented.

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 Request

Port No: _____ SS # (last 4) XXX-XX-☐☐☐☐

Name: _____

E-Mail Address: _____ Phone: _____

I authorize the HRSA-ILA and my financial institution to transfer the benefit(s) selected below into my account.

☐ Monthly Pension benefit

☐ Quarterly Medicare premium reimbursement

(Check all that apply)

Financial Institution: _____

Type of Account: Checking ☐ Savings ☐

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

Transit Routing # Bank Stamp:

|__|__|__|__|__|__|__|__|__|

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

I acknowledge and agree that if funds to which I am not entitled are deposited to my account, I authorize HRSA-ILA and the financial institution to return said funds. This direct deposit election and my authorization are to remain in effect until cancelled in writing. I acknowledge that HRSA-ILA has no control over the accessibility of funds in my account after the direct deposit is made and that I am responsible for maintaining current account information to HRSA-ILA by required deadline.

Participant Signature: _____ Date: _____