THIS FORM CANCELS ALL PREVIOUS DIRECT DEPOSIT REQUESTS.

HRSA-ILA Direct Deposit Request
Pension and Medicare Benefits

Elections received later than 1 week before a benefit payment date can not be implemented. Use this form to start, change, or cancel direct deposit of your **Pension** or **Medicare** benefit. **Pension and Medicare** benefits are **mandatory direct deposit**.

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. **I hereby cancel my previous authorization for direct deposit** of HRSA-ILA benefits selected below. I **understand that this form must be completed one calendar week before the benefit check date** to be in effect. **(Check all that apply.)**

☐ **Pension benefit** ☐ **Medicare Reimbursement benefit**

PRIMARY ACCOUNT

Account Type: _____ **Checking** _____ **Savings**

Financial Institution: _____

SECONDARY ACCOUNT

Account Type: _____ **Checking** _____ **Savings**

Financial Institution: _____

Amount to be deposited: _____ **or** ☐ **Please stop Secondary EFT or** ☐ **No change to existing Secondary EFT**

Effective Date: _____

Attach a voided check here or have your financial institution provide a bank letter confirming your account information for direct deposit.

- **Direct deposit request will not be accepted without either a check or bank letter**
- Starter checks for direct deposit not accepted without account holder's name on it
- 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:** _____