UA LOCAL 190 HEALTH AN D WELFARE PLAN
SUB PLAN
PAYEE DEPOSIT AGREEMENT

Name of Payee _____ SS# _____

Address _____ City _____ State _____ Zip _____

Telephone No. (____) _____

I, the undersigned, hereby authorize the Board of Trustees of the UA Local 190 Sub Plan to deposit all amounts due to me under the Sub Plan in my account at the Financial Institution named below. This authorization shall remain in force as long as I am eligible to receive Sub benefits. If, due to lack of knowledge of my back to work status, the Sub Plan distributes benefit checks after I have returned to work for deposit in my account, I authorize and direct the Financial Institution to refund the Sub Plan.

Signature _____ Date _____

Witness _____ Date _____

AGREEMENT BY FINANCIAL INSTITUTION

The Financial Institution named below, agrees to accept for deposit in the account specified below benefit checks payable by the UA Local 190 Sub Plan. The Financial Institution agrees to refund to the Sub Plan the amount of any Sub benefit check deposited in the Payee's account, which represents Sub benefits paid after the payee has returned to work, provided that the amount of the deposits remain in the account at the time the request for a refund is received from the Sub Plan.

Name of Financial Institution _____

Can you accept "Automated Clearing House" transactions? ❑ Yes ❑ No

Bank ABA Number _____ Account Number _____

Type of Account: ❑ Checking/Sharedraft ❑ Savings

Branch _____ Address _____

City _____ State _____ Zip _____

Signature of Representative _____ Date _____

Title _____

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