

# DIRECT DEPOSIT AGREEMENT

Name of Retiree \_\_\_\_\_ Social Security No \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No (      ) \_\_\_\_\_

**Bank Account Information** – Attach a voided check from your account and/or complete the information below. See sample check at the bottom of the page for help completing this section. **PLEASE PRINT CLEARLY.**

Routing No.         Account No. \_\_\_\_\_

Type of Account:  Checking  Savings

## Financial Institution

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I, the undersigned, hereby authorize the Board of Trustees of the VEBA Trust Fund ("the Pension Fund") to deposit all amounts due to me under the Health Reimbursement Plan in my account at the Financial Institution named above. This authorization shall remain in force until I revoke it in writing or until my death, whichever occurs first. If at any time the VEBA Fund should credit my account for a benefit to which I am not entitled, I authorize and direct the Financial Institution to refund the VEBA Fund.

Retiree Signature \_\_\_\_\_

Date \_\_\_\_\_

Spouse Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please allow up to 45 days for the direct deposit set-up process to be completed.**

**RETURN FAX#**  
**(248) 556-2597**

