IBEW AECA FAMILY HEALTH

IBEW LOCAL 613 & CONTRIBUTING EMPLOYERS FAMILY HEALTH PLAN
3715 Northside Parkway • Suite 2-495 • Atlanta, Georgia 30327
1.800.922.1613 • www.nebainc.com

IBEW Local 613 & Contributing Employers Family Health Plan
Weekly Disability Authorization of Benefit Payment Method

SECTION 1 – EMPLOYEE INFORMATION

Employee Name	First MI Last		**SSN**	- -	
Phone Number	( ) -	**Date of Birth**	/ / MM / DD / YYYY	**Local Union**	**IBEW 613**
Home Address	Street Address				
	City		State	Zip Code	

SECTION 2 – METHOD OF BENEFIT PAYMENT

Provide information on how you would like to receive your benefits (choose one)

☐ Please pay my benefits via direct deposit to the following bank account (complete the fields below)

Account type:	☐ Checking ☐ Savings	**9-Digit Bank ABA routing number:**	
Account number:			

This authorizes the IBEW Local 613 and Contributing Employers Family Health Fund (the "Fund") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method to my account indicated above and other accounts I identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries. I agree that the ACH transactions authorized herein shall comply with all applicable U.S. Law. This authorization will be in effect until the Fund receives a written termination notice from myself and has a reasonable opportunity to act on it.

Authorized Signature:

Print Name:		**Date:**	

☐ Please pay my benefits via check, mailed to the address shown above in SECTION 1.