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 Form

Port No: ____________________________ SS #: ____________________________________

Participant Name: ____

Participant E-Mail Address: ____

I authorize HRSA-ILA and the financial institution listed below to credit automatically to the indicated deposit account my:

☐ Monthly Pension benefit

☐ Quarterly Medicare premium reimbursement

(Check all that apply)

payable to me by the appropriate fund. If amounts to which I am not entitled are deposited to my account, I authorize HRSA-ILA Funds to direct the financial institution to return said amounts. This authority is to remain in effect until canceled in writing.

Financial Institution: ____

City: ______________________________ State: ____________ Zip: ____________

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.

Bank Stamp:

Transit Routing # _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

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

Participant Signature: ____

Date: ____________________________

Form D-1

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