HRSA-ILA

Authorization to Cancel Direct Deposit

Port No: _____ SS # (last 4) XXX-XX-☐ ☐ ☐ ☐

Name: _____

E-Mail Address: _____ Phone: _____

    I hereby cancel my previous authorization for direct deposit of HRSA-ILA benefits checked below.

☐ Please send me a new direct deposit form.

Please **cancel direct deposit** for my: Name of Bank
(Check all that apply)

_____ Monthly Pension benefit   _____

_____ Quarterly Medicare   _____
premium reimbursement

_____ Vacation & Holiday benefit   _____

_____ Container Royalty benefit   _____

The cancellation should be effective for the next benefit payment date: _____

I understand that this form must be filed at least one calendar week before the benefit check date. I understand that if I do not timely file a new direct deposit authorization form, my Vacation & Holiday, or Container Royalty checks will be automatically mailed to my permanent home address currently on file at the Fund Office.

Participant Signature: _____

Date: _____

FORM D-3
REV 1/7/2016