

Short-Term Disability Direct Deposit Authorization

St. Louis – Kansas City Carpenters Regional Health Plan

1419 Hampton Avenue, St. Louis, MO 63139

Phone: (314) 644-4802 | Toll-Free: (877) 232-3863 | Fax: (314) 678-1110 | Email: benefits@laborfunds.org



Participant Name (Last, First, Middle Initial)	Last 4-digits of SSN
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Please complete this form and return it to the address at the top of this form. **Note: You will need to continue to receive your benefits by check until you receive verification from our office confirming your automatic payment effective date.**

To the Trustees of the St. Louis – Kansas City Carpenters Regional Health Plan (Plan), I hereby request that my short-term disability benefit be electronically deposited into my account as authorized by my signature below.

Bank details: Debit from bank account: Checking Account Savings Account
 Attach a voided check Use account information from your statement, not deposit slip.

Name of Financial Institution	Transit Routing Number
City and State of Financial Institution	Bank Account Number

I understand that the Trustees have discretion whether to comply with this request. I understand I may cancel or change this authorization for deposit into the account selected above by written notice to the Plan at least ten days prior to a change in payment method may take place. I certify this authorization will remain in effect until either (1) I provide written notice to cancel this request, (2) the bank/account I selected rejects my deposit. My signature on this authorization indicates that I authorize the verification of the above information by the financial institution of the Plan's Trustees or their designated representative. I consent that a copy of this authorization may be considered as valid as the original.

Participant Signature: _____ Date: _____

For Office Use Only			
Rate Type	Amount	Pymt Effective Date	Auth By & Dte