INLAND

Refrigeration & Air Conditioning

Health & Welfare Trust Fund

Paid Time Off Benefit

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT (ACH CREDITS)

I hereby authorize the Inland Refrigeration and Air Conditioning Health and Welfare Trust Fund ("Fund Office") to pay my normal plan benefits (in December, or my free quarterly interim withdrawal) to my bank account indicated below.

If any payment is deposited to the account, and if I am not entitled to such payment for any reason, I hereby authorize the Fund Office to directly debit my account and to direct the financial institution to refund to the Fund Office the amount of any such payment.

To ensure my deposits will be properly credited I authorize the financial institution indicated to confirm to the Fund Office the accuracy of the specific financial institution and account information supplied below.

BANK ACCOUNT NUMBER	**BANK TRANSIT/ABA/ROUTING NUMBER**
NAME OF FINANCIAL INSTITUTION (Bank, Credit Union, etc.)	**TYPE OF ACCOUNT** (Check one) ☐ **CHECKING** ☐ **SAVINGS**
E-MAIL (Required to send ACH correspondences)	**SOCIAL SECURITY NUMBER** (Only last four digits required) - -

I understand that:

1. This authorization will remain in effect until the Fund Office has received written notification from me of its termination (whereupon I will revert to receiving benefits by check). The deadline for such notice is the 20th of the month before the month of payment.
2. No fee is charged for this service. The Trustees may impose a fee as needed.
3. I must be the owner or a co-owner of the bank account listed above.
4. I must attach a voided check (or deposit slip in the case of a savings account), or this form will be rejected.
5. This form and attachment must be received by the Fund Office by the 20th day of the month in order for a direct deposit to be made during the following month.
6. The account must be open and capable of receiving deposits at the time of the direct deposit. If not, the funds will be returned to the Fund Office and will be unavailable until (1) the Participant submits a revised Direct Deposit Election form; or (2) the Participant rescinds his or her Direct Deposit Election form (in which case a check will be issued), or (3) the next normal December benefit payment (in which case a check will be issued).

PARTICIPANT SIGNATURE	**PRINT NAME** (Must be Name of Account Holder)	**DATE**
X		

PLEASE VERIFY BANK ACCOUNT DATA

YOU MUST ATTACH A VOIDED CHECK (OR DEPOSIT SLIP FOR A SAVINGS ACCOUNT)

FAX TO (213) 386-0418, EMAIL TO info@SCPTAC.org OR MAIL TO THE FUND OFFICE

Administered by

SOUTHERN CALIFORNIA PIPE TRADES ADMINISTRATIVE CORPORATION

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