## AMALGAMATED TRANSIT UNION DIVISION 757 RETIREE HEALTH AND WELFARE PLAN

## DIRECT DEPOSIT AUTHORIZATION

BOBGADOTTI@GMAIL.COM

Routing Number:	Direct Deposit: ( ) YES or NO ( )
Account Number:	Financial Institution/ with Address:
Account Number:	
Type: ( ) Checking Account ( ) Savings Account I hereby authorize EFT deposit to my financial institution for my monthly C-Tran Medical Trust Retiree benefit payment.  NAME (PRINT)	Routing Number:
( ) Checking Account  I hereby authorize EFT deposit to my financial institution for my monthly C-Tran Medical Trust Retiree benefit payment.  NAME (PRINT)	Account Number:
I hereby authorize EFT deposit to my financial institution for my monthly C-Tran Medical Trust Retiree benefit payment.  NAME (PRINT)	Type: ( ) Checking Account
Retiree benefit payment.  NAME (PRINT)	( ) Savings Account
SIGNATURE  DATE  EMAIL: PHONE:  SEND COMPLETED FORM TO;  TRUST ADMINISTRATOR	I hereby authorize EFT deposit to my financial institution for my monthly C-Tran Medical Trust Retiree benefit payment.
DATE  EMAIL:  PHONE:  SEND COMPLETED FORM TO;  TRUST ADMINISTRATOR	NAME (PRINT)
EMAIL: PHONE:  SEND COMPLETED FORM TO;  TRUST ADMINISTRATOR	SIGNATURE
PHONE:  SEND COMPLETED FORM TO;  TRUST ADMINISTRATOR	DATE
SEND COMPLETED FORM TO; TRUST ADMINISTRATOR	EMAIL:
TRUST ADMINISTRATOR	PHONE:
	SEND COMPLETED FORM TO;
	C/O BOB GADOTTI
29866 GADOTTI DR. SCAPPOOSE, OR 97056	
OR EMAIL	·