AMALGAMATED TRANSIT UNION
DIVISION 757
RETIREE HEALTH AND WELFARE PLAN

DIRECT DEPOSIT AUTHORIZATION

Direct Deposit: ( ) YES or NO ( )

Financial Institution/ with Address:

_____

_____

Routing Number: _____

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)_____

SIGNATURE_____

DATE_____

EMAIL: _____

PHONE: _____

SEND COMPLETED FORM TO;

TRUST ADMINISTRATOR
C/O BOB GADOTTI
29866 GADOTTI DR.
SCAPPOOSE, OR 97056
OR EMAIL
BOBGADOTTI@GMAIL.COM