MRP CLAIMS

417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
Tel. (212) 580-9092 or (800) 456-3863
Fax (646) 783-7650 /Email to claims@iatsenbf.org

AUTHORIZATION AGREEMENT FOR ELECTRONIC TRANSFER

Name: _____ SSN:_____ID# _____

Address: _____

City: _____ State: _____ Zip Code _____

Phone: (_____) _____ Email Address: _____

I hereby authorize the I.A.T.S.E. Medical Reimbursement Program, to initiate credit and debit entries in connection with the distribution to my account as designated below at the financial institution (the "Depository") named below and to credit or debit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with all applicable provisions of U.S. law.

Bank Name: _____

Phone: (_____) _____

Account Type (check one): ☐ Checking ☐ Savings

Account Number: _____

9 Digit ACH Routing Number

(Ask your bank to furnish the routing # or send us a VOIDED check for your account)

This authorization is to remain in full force and effect until the Fund has received written notification from me of it termination in such time and in such manner as to afford the Fund and the Depository a reasonable opportunity to act on it.

Signature of Plan Participant _____ Date _____

***Please note verification will be required before approving your request.**