



Direct Payment Plan Form - Retirees

Instructions:

1. Mark the box before "type of account" to indicate whether your payment will be deducted from your checking or savings account.
2. Fill in your name, the name of your bank, the bank's address and date.
3. **Attach a voided check for verification of all bank information.** If you are unable to attach the voided check, please fill in your account number and routing number. These numbers are located on the lower left of your check. ***Please be sure to sign the form.***

I, _____, residing at _____

Telephone () _____ authorize the CSEA Employee Benefit Fund to initiate electronic debit entries to my:

_____ Checking _____ Savings account for payment of my dental premiums.

I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until I have cancelled it in writing.

Date: _____

Financial Institution Name (Please Print) _____

Account Number at Financial Institution: _____

Financial Institution Routing Number: _____

Financial Institution City and State: _____

Signature: _____

Return to: CSEA Employee Benefit Fund, One Lear Jet Lane, Suite 1, Latham, NY 12110