

MICHIGAN ELECTRICAL EMPLOYEES HEALTH PLAN
AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS
BY ELECTRONIC TRANSFER

I hereby authorize the **MICHIGAN ELECTRICAL EMPLOYEES HEALTH PLAN** to deposit my Loss-of-Time Disability Benefit ("Benefits") to the account maintained at the bank or financial institution identified below, and authorize the bank or financial institution to accept these deposits. I understand that my eligibility to receive Benefits is governed exclusively by the terms of the Fund's governing documents.

This authorization is to remain in full force and effect until the Fund has received written notification of its termination from me at such time and in such manner as to afford the Fund a reasonable opportunity to act on it. If Benefits to which I am not entitled are deposited to my account, I authorize the Fund to direct the bank or financial institution on my behalf to return the full amount of said benefit immediately to the Fund. In the event the Fund makes an overpayment that cannot be collected from the bank or financial institution, I agree to repay the Fund.

I agree that these deposits and adjustments, if any, may be made electronically and under the Rules of the Michigan Automated Clearing House Association (ACH).

Please print or type:

Name of Bank or Financial Institution: _____

Address of Bank or Financial Institution: _____
Street

_____ City State Zip Code

Contact Person at Bank or Financial Institution : _____

Phone Number: _____

Type of Account (check one): Checking (ATTACH A VOIDED CHECK) OR Savings

DFI's Routing & Transit No. _____

Account No. to Credit _____

Name of Person Authorizing Transfer: _____

Social Security or ID Number: _____ Local Union No: _____

Current Address: _____
Street City State Zip Code

Date: _____ Signature: _____

PLEASE ATTACH TO THIS AUTHORIZATION A BLANK OR VOIDED CHECK ON THE ACCOUNT INTO WHICH DEPOSITS ARE TO BE MADE AND RETURN TO:

MICHIGAN ELECTRICAL EMPLOYEES HEALTH PLAN
3001 Metro Dr. Suite 500
Bloomington, MN, 55425