DIRECT DEPOSIT FORM

Please be advised, effective November 1, 2022, cheques will no longer be issued for claim payments. Please provide our office with your banking details for EFT, (Electronic Fund Transfer) along with your email address as soon as possible to ensure there will be no interruption in claim payment.

Plan Member Name: _____

Plan Member ID Number: _____
(please refer to your prescription medication card for this number)

Plan Member Address: _____

Plan Member Primary Phone Number: _____

Plan Member Email Address: _____

Banking Information must be accompanied by a void cheque or statement for authorization for Direct Deposit which may be obtained from your financial institution or in most cases through your on-line banking. Account holder must be the Plan Member.

Name of Financial Institution: _____

Address of Financial Institution: _____

Financial Institution Number: _____

Transit/Branch Number: _____

Account Number: _____

I hereby:

(i) request and authorize the Plan to deposit eligible claim payments to the aforementioned account;

(ii) consent to receiving any information in respect of such deposits, including statements, electronically (instead of paper copies) at the email address provided above (or such other email address as I may later provide to the Plan);

(iii) consent to the collection, use and disclosure of the personal information requested on this form by the Plan (and its agents) for the purpose of processing such deposits; and

(iv) agree that any deposit made in error must be returned to the Plan and may be offset from any other payment due to me from the Plan.

Date: _____ Plan Member Signature: _____

1610 Kebet Way, Port Coquitlam, British Columbia V3C 5W9 Tel: 604-552-2650 Toll Free: 1-888-478-8111 Email: benefits.pensions@teamstersbenefits.ca Fax 604-552-2653

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