

**RETIREE MEDICAL PLAN OF THE SANTA MONICA POLICE OFFICERS'
ASSOCIATION REIMBURSEMENT TRUST**

Administered By: Benefit Programs Administration
Telephone: (562) 463-5050 Fax: (562) 463-5894 www.smpoatrust.org

AUTHORIZATION FOR ELECTRONIC DEPOSIT OF PENSION BENEFITS (EFT)

Name (Please type or print)

Social Security Number

Mailing Address

Telephone Number

City

State

Zip

I hereby authorize the RETIREE MEDICAL PLAN OF THE SANTA MONICA POLICE OFFICERS' ASSOCIATION REIMBURSEMENT TRUST to electronically transfer my pension benefits, including corrections, to my (please check one of the following):

☐

Checking Account

☐

Savings Account

☐

Other Account

Bank's Transit Routing Numbers (ABA No.)

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Account No.

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Please attach a VOIDED CHECK or a Savings Account DEPOSIT SLIP to this Form.

This authorization shall remain in effect until the RETIREE MEDICAL PLAN OF THE SANTA MONICA POLICE OFFICERS' ASSOCIATION REIMBURSEMENT TRUST has received written notification of its termination, or until the Trust has sent me written notice of its termination. I understand that any funds received by the designated financial institution after my death are to be returned to the Trust and I authorize the financial institution to refund the same to the Trust and charge all payments to this account.

Funds are to be deposited at the following:

Name of Financial Institution (Please type or print)

Address

Street

City

State

Zip

Names (s) on Account (Please type or print)

SIGN HERE

Your Signature

Date

Joint Account Holder's Signature (A Joint Account requires both Signatures)

Date

ATTACH HERE

VOIDED CHECK OR DEPOSIT SLIP FOR ABOVE ACCOUNT

Once this form has been completed it is to be returned to the Administrative Office.