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.) ☐☐☐☐☐☐☐☐☐

Account No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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 REIMBUREMENT 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)

_____ _____
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.