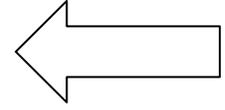
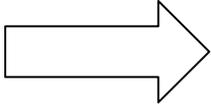




Please attach your voided Check Here



Administrative Use Only

ACH start date: _____

EBF ID Number: _____

**RETIREE DENTAL PLAN
Direct Payment Plan Form**

The CSEA Employee Benefit Fund is pleased to offer the option to have premiums deducted from a checking or savings account on a monthly basis. When Direct Payment is selected, deductions will commence on the **1st of the following month your coverage starts.**

Instructions:

1. Fill in your name, address and telephone number with area code. **Please print**
2. Indicate which type of account payments are to be deducted from.
3. Provide the name of your financial institution, routing number and account number.

*The **routing number** is the **first set of numbers** on your check (9 digits)

The **account number** is the set of numbers **closest to the signature line on your check.**

Example: 089685746 : 978685746352 1234 _____

Routing Number Account Number check# Signature Line

4. Fill in the amount to be deducted from your account.
5. Attach a voided check for verification of bank information **if using a checking account.**
6. Please be sure to sign and date 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 monthly premiums.

Financial Institution Name: _____

Financial Institution City and State: _____

Routing Number: _____ **Account Number:** _____

Amount to be deducted: _____

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

Signature: _____

Date: _____

Return to:
CSEA Employee Benefit Fund, Retiree Unit, PO Box 516, Latham, NY 12110