

Short Term Disability Plan Authorization Agreement for Electronic Funds Transfer

Employee Information All sections to be completed in full unless otherwise indicated.			
Full name	First, middle, and la	st SSN	###-##-####
Address	Street address or PO box, city, state, and zip code	hone	(###) ###-####
Email			
Emergency Contact			
Full name	First, middle, and last	hone	(###) ###-####
Bank or Financial Institution Information			
Please Note: MCC is required to verify the information below with your bank. If any information is incorrect, the electronic deposit of your check may be delayed. In that instance, a Paycard will be mailed to your home address until banking information is correctly verified with your bank.			
Name	P	hone	(###) ###-###
Routing number ######## Account number	Т	ype of account:	Checking Savings
Note: If this is a checking account, please attach a voided check here.			
Signature You must sign and date this form for it to be valid.			
I hereby authorize Michigan Catholic Conference (MCC) to deposit my Short Term Disability Plan (Plan) check in the bank account identified above. I understand this will remain in effect until written notice of termination is given to MCC.			
If any deposits are made to my account subsequent to my death to which I am not entitled under the terms of the Plan, I hereby authorize and direct the Bank on behalf of my estate, my heirs, and my beneficiaries to refund said deposits to the Plan and to charge the same to my account. I further authorize the Bank to accept a written determination from a representative of MCC that I was not entitled to any such deposits made to my account subsequent to my death.			
Signature		Date	MM/DD/YYYY

Please return completed form by email to benefits@micatholic.org, fax to (517) 316-3690, or mail to:

Michigan Catholic Conference Attention Benefits Department 510 South Capitol Avenue Lansing, Michigan 48933