TELECOMMUNICATION WORKERS LONG TERM DISABILITY PLAN
ELECTRONIC FUNDS TRANSFER REQUEST FORM

Telephone: (604) 430-1317 • Facsimile (604) 430-5395

Bank Stamp

Member's Name:

_____

Member's Address:

_____

_____

_____

SECTION A: To Be Completed By Your Banking Institution

Name of bank: _____

Inst. No. Branch No. Account No.

Is this a joint account? Yes ☐ No ☐

_____ _____

Signature of Financial Institution Official Telephone No.

SECTION B: To Be Completed By You

I hereby authorize the Trustees of the Telecommunication Workers LTD Plan ("the Plan") to deposit all disability payments due me under the terms of the Plan directly into the account named above.

I acknowledge that although no amounts may be payable to me or my estate by the Plan after my death, it is possible that direct deposits to my account may continue until the Plan is notified of my death and terminates the direct deposits. In consideration of the Plan agreeing to make direct deposits to my account, I hereby agree that:

1. Any monies directly deposited to my account after my death, which, under the terms of the Plan are not payable to my estate, are held in trust for the Plan and are to be repaid to the Plan forthwith;
2. The Administrator of the Plan is entitled to request from time to time satisfactory evidence that I am alive and therefore that LTD benefits continue to be payable to me under the Plan. The Administrator may, in his/her discretion, discontinue the direct deposit of my LTD payments and instead make payments by cheque until such evidence has been received by him/her; and
3. These agreements are binding upon me and upon my heirs, executors, administrators and personal representatives.

This authority will remain in effect until I have given the Plan written notice to terminate it. I understand that I must give the Plan enough notice to allow reasonable time to act on my instructions. In the event an overpayment should be credited to my account during or after my lifetime, I authorize the Plan to direct my banking institution to refund same to the Plan and charge such payment to my/our account.

A JOINT ACCOUNT REQUIRES AN ADDITIONAL SIGNATURE

_____ _____

YOUR SIGNATURE (DISABLED MEMBER) SIGNATURE OF JOINT ACCOUNT HOLDER

_____

SOCIAL INSURANCE NUMBER

_____ _____

YOUR TELEPHONE NUMBER DATE

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