ENROLLMENT FOR PENSION PAYMENT BY ELECTRONIC FUNDS TRANSFER

This form is for: ☐ An initial request for EFT payments ☐ A change to existing enrollment

Participants may elect to receive benefit payments through Electronic Funds Transfer (EFT) by submitting a completed authorization form. The UMWA 1974 Pension Trust reserves the right to verify participant identity prior to establishing or modifying EFT instructions. Any changes to banking information must be submitted in writing and may be subject to verification procedures before processing. Participants may modify or cancel EFT instructions by submitting written notice to the Trust. The Trust recommends that requests be submitted sufficiently in advance of scheduled payments to allow processing time. The Trust will make reasonable efforts to process EFT requests accurately; however, participants are responsible for promptly notifying the Trust of any changes to banking information or suspected payment irregularities.

1. Payee Information

Name _____ Mine Worker Funds ID _____

Payee Social Security Number _____ Phone Number _____

Payee Mailing Address _____ City, State, Zip Code _____

2. Financial Institution

☐ Checking ☐ Savings

Check one type of account

Name of Financial Institution _____ Phone Number _____

Branch Address _____ City, State, Zip Code _____

Required: Attach Voided Check* Here

*If a pre-printed check or direct deposit slip is not available, an official direct deposit form from your bank, which verifies the name(s), current mailing address, account number and routing number must be attached. The EFT form and supporting document(s) must be mailed. However, it may be faxed directly from the financial institution to the Funds at (202) 521-2353. All EFT transactions will be recorded and made available for review upon request as required by applicable regulations.

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EFTCOVER

3. Payee Authorization

By signing this form, I acknowledge and authorize the UMWA 1974 Pension Trust (the Trust) and the financial institution listed below to electronically deposit my benefit payments into my designated account each month. Additionally, I authorize the Trust to direct my financial institution to return any payments to which I am not entitled. This authorization shall remain in effect until I provide written notice of cancellation to the UMWA Health & Retirement Funds (the Funds) Eligibility Services Department.

_____ _____

Payee Signature Date

_____

Payee Name (Printed)

4. Joint Account Holder Information (Leave Blank if not a Joint Account)

I hold the above account jointly with the account holder with the individual named above. I agree to notify the Funds promptly upon the death of the Payee. I authorize the Trust to direct my financial institution to return any payments made to the joint account to which the Payee is not entitled. If such payments cannot be recovered through debits to the account, the Trust may recover any such payments from the Joint Account Holder to the extent permitted by applicable law.

_____ _____

Joint Account Holder Signature Date

_____

Joint Account Holder Name (Printed)