



National Asbestos Workers Medical Fund

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Administered by:
NEBA
NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC.



Short Term Disability Authorization of Benefit Payment

SECTION 1 - EMPLOYEE INFORMATION

1.	Employee Name		2.	SSN (last 4)	XXX-XX-
3.	Date of Birth		4.	Telephone Number	
5.	Address				
6.	City		7.	State/Zip	

SECTION 2 – METHOD OF PAYMENT (choose one)

Please pay my benefits via check, mailed to the address shown above in SECTION 1

Please pay my benefits via direct deposit to the following bank account

1.	Account type: (check one)	<input type="checkbox"/> Checking <input type="checkbox"/> Savings	2.	Bank ABA routing number:	
3.	Account number:				

This authorizes the National Asbestos Workers Medical Fund (the "Fund") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method to my account indicated above and other accounts I identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries. I agree that the ACH transactions authorized herein shall comply with all applicable U.S. Law. This authorization will be in effect until the Fund receives a written termination notice from myself and has a reasonable opportunity to act on it

Employee Signature: _____ Date: _____