Insulators and Allied Workers National Medical Fund
2010 N.W. 150th Avenue, Suite 200 | Pembroke Pines, FL 33028
Toll Free: (888) 352.0629 | West Coast Toll Free: (888) 987.0629
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Administered by: NEBA

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)**	☐Checking ☐ Savings	**2.**	**Bank ABA routing number:**	
3.	**Account number:**				

This authorizes the Insulators and Allied Workers National 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: _____