



RETIREE SUPPLEMENTAL HEALTH PLAN

AUTHORIZATION FORM

Check one:

AMSA

MTA

CSEA

(Please Print)

Date: _____

Name: _____ Social Security Number: _____

Address: _____

Telephone Number: _____ Email Address: _____

I elect to stay with Camino Federal Credit Union

I elect another institution (Please fill out below)

Name of Bank: _____

Bank Address: _____

Bank Routing Number: _____

Bank Account Number: _____

Type of Account: Checking* Savings

****Please submit a voided check with your completed form ONLY IF ELECTING OTHER INSTITUTION.**

I HEREBY AUTHORIZE RETIREE SUPPLEMENTAL HEALTH PLAN TO DEPOSIT A PREMIUM REIMBURSEMENT/ DEDUCT PREMIUMS FOR DENTAL, VISION, TO THE ACCOUNT DESIGNATED ABOVE.

Signature: _____

MAIL OR FAX TO:

**MTA Retiree Supplemental Health Plan
3444 Camino Del Rio North, Suite 101
San Diego, CA 92108
Ph. (800) 886-7559, Fax (619) 501-3250**