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 <u>ONLY IF ELECTING OTHER INSTITUTION.</u>**

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
3530 Camino Del Rio North, Suite 110
San Diego, CA 92108
Ph. (800) 886-7559, Fax (619) 501-3250

Montebello USD Benefits Department Ph. (323) 887-7900 ext. 2302 or 2338