



Hawaii Employer-Union Health Benefits Trust Fund (EUTF) Direct Deposit Agreement Form

First Name		Middle Initial	
Last Name		SSN:	

ACT 039, SLH2006, signed by the Governor on April 27, 2006, permits the Hawai'i Employer-Union Benefits Trust Fund to require individuals who become eligible for Medicare Part B reimbursements on or after July 1, 2006 to accept direct deposit of Medicare reimbursements to a financial institution of their choice.

Authorization Agreement

I hereby authorize the Hawaii Employer-Union Health Benefits Trust Fund ("EUTF") to automatically and directly deposit Medicare Part B premium reimbursements to my account at the financial institution named below ("Financial Institution"). I also authorize the EUTF to make withdrawals from my account in the event that Medicare Part B premium reimbursements have been made to my account in error, e.g., overpayments. Initial _____

I hereby consent to the Financial Institution disclosing any information to the EUTF as necessary to effectuate, administer, or enforce the transactions authorized above. Initial _____

I agree not to hold the EUTF responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by Financial Institution or due to an error on the part of Financial Institution in depositing funds to my account. Initial _____

Account Information (to be completed by the financial institution)

Name of Account Holder(s):			
Name of Financial Institution:			
Routing Number:			
Account Number:		Checking <input type="checkbox"/>	Savings <input type="checkbox"/>
Financial Institution Certification:			
Name of Agent: _____			
Signature: _____		Date: _____	

Certification by Account Holder(s)

Authorized Signature (Primary):		Date:	
Authorized Signature:		Date:	

Please attach a voided check or deposit slip and return this form to the EUTF.

EC-2

INSTRUCTIONS

The 2006 State Legislature passed Act 39 which was signed into law by the Governor on April 27, 2006. The act establishes the requirement for all individuals who become eligible for Medicare Part B reimbursements on or after July 1, 2006 to accept direct deposits to the institution and account of their choice.

The employee/retiree must complete the top portion of the form to include the full name and social security number. Failure to complete this section will void this form. In addition, if there is any alteration of this form, a new form must be completed. If there is a change to your account, you will need to submit a new form. The most recently dated form submitted to the EUTF will apply.

The employee/retiree should carefully read each paragraph under the Authorization Agreement and initial after each paragraph. Your initial indicates that you fully understand and agree to the contents in each paragraph. Failure to initial where required will void this form.

Once you are completed with the first half of this form, take this form to your financial institution to complete the Account Information section. The employee/retiree's name must appear on the account. Please ensure that this section is signed by a representative of the financial institution.

Before returning this form to the EUTF, please ensure that you complete the "Certification of Account Holder(s)" section. The employee/retiree signs as the primary account holder. If the account is a joint account, please have the joint account holder(s) sign the form. Use an additional sheet if necessary. If you are representing the employee/retiree, please ensure that you have an authorizing document on file with the EUTF. If not, please send in the authorization with this form.

If you have any questions, please contact the EUTF Customer service at:

Oahu: 808-586-7390

Toll-Free: 800-295-0089

Email address: eutf@hawaii.gov EUTF Website: www.eutf.hawaii.gov

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