

# HRSA-ILA

## Authorization to Cancel Direct Deposit

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Port No: \_\_\_\_\_ SS #: \_\_\_\_\_

Participant Name: \_\_\_\_\_

I hereby cancel my previous authorization for direct deposit of my HRSA-ILA benefits checked below. I understand that if I do not timely file a new direct deposit authorization form, my benefit checks will be automatically mailed to my permanent home address currently on file at the Fund Office.

Please **cancel direct deposit** for my:  
(Check all that apply)

Name of Bank

_____ Monthly Pension benefit	_____
_____ Quarterly Medicare premium reimbursement	_____
_____ Vacation & Holiday benefit	_____
_____ Container benefit	_____

The cancellation should be effective for the next check date of: \_\_\_\_\_

***I understand that this form must be filed at least one calendar week before the benefit check date.***

Please send me a new direct deposit form.

Participant Signature: \_\_\_\_\_

Date: \_\_\_\_\_