

MONTEBELLO TEACHERS ASSOCIATION RETIREE SUPPLEMENTAL HEALTH PLAN

AUTHORIZATION FORM

(Please Print)

Date: _____

Retirement Date: _____

Name: _____ Social Security Number (Last 4): _____

Address: _____

Telephone Number: _____ Email Address: _____

___ I elect Camino Federal Credit Union (Please fill out below)

___ 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 if checking account.

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

Check all that apply:

___ Premium Reimbursement ___ Trust Contribution ___ Dental ___ Vision ___ Annual Dues

Signature: _____

Please submit your completed form to the MTA Retiree Supplemental Health Plan
3530 Camino Del Rio North, Suite 110
San Diego, CA 92108
Phone (800) 886-7559
Fax (619) 501-3250