

DISABILITY DIRECT DEPOSIT AUTHORIZATION FORM

I authorize Deseret Mutual Benefit Administrators and the financial institution shown below to deposit my disability payments directly to my bank/credit union account each month. This authorization will remain in effect until I file a new authorization form.

Name of Financial Institution

Address of Financial Institution

Type of Account (Check One): **Checking** _____ **Savings** _____

Participant's Name (please print as name appears on check)

Participant's Signature

CHECK ONE:

_____ **Direct Deposit my disability payment to the bank/credit union shown above**

_____ **Stop my direct deposit and mail my disability payment directly to my home**

_____ **Change my direct deposit to the bank/credit union shown above**

**TAPE YOUR VOIDED CHECK HERE
(DO NOT USE A DEPOSIT SLIP)**