AUTHORIZATION FOR AUTOMATIC DEPOSIT OF DISABILITY BENEFIT PAYMENT

If my application for Disability Plan benefits is approved, I hereby authorize DMBA or its administrator to send my Disability Plan benefit payment to the financial institution indicated below for direct deposit into my account.

Check one: ❑ Bank ❑ Credit Union

Please attach a ***voided check*** *below to show DMBA or its administrator the exact position of your account number.*

(A deposit slip will *not* be accepted.)

Financial Institution, Routing Transit Number, and Account Number:

Institution name: _____

Institution routing transit number: _____

Account number: _____ Check one: ❑ Checking account ❑ Savings account

Institution street address: _____

City: _____ State:_____ ZIP Code:_____Phone number: _____

I understand that I may end or change this agreement at any time by notifying DMBA or its administrator in writing, allowing DMBA or its administrator reasonable time to act upon my notification.

_____	_____	_____
NAME PRINTED	SIGNATURE	DATE

Check one: ❑ Add: Deposit my pay to the account shown.

❑ Cancel: Stop my direct deposit.

❑ Change: Change my financial institution and/or account number.

Because of the required time for processing, any forms received after the 20th of the month may not be directly deposited until the following monthly payroll period. You will receive a regular paycheck until the change is processed.

* The Hartford is The Hartford Financial Services Group, Inc. and its subsidiaries, including the underwriting company Hartford Life and Accident Insurance Company.