Local Unions Supplemental Pension and Severance Fund Trust
365 Route 304, Suite 204, Bardonia, NY 10954
Tel 845-367-7625 | Fax 845-501-4153
www.lusptrust.org
general@lusptrust.org

ACCOUNT CHANGE FORM

Complete form in its entirety, then fax, email, or return to the address above.

Member Information – Please Print Clearly

Name ____________________________ Social Security # _________________ Date of Birth ___________

Address _______________________________________ City _________ State ______ Zip _____________

Home Phone ___________________ Work Phone _________________ Cell Phone __________________

Email Address ____

Action Requested:

☐ I have indicated a change of: ☐ Name ☐ Address

☐ I wish to change:

☐ **Payroll deductions** (per pay period)

☐ **Automatic deductions** from my financial institution account on a monthly basis. Deductions will occur on the 15th of the month or the following business day.

Check one: ☐ $7.00 ☐ $14.00 ☐ $21.00 ☐ Other $____________ (Must be in multiples of $7.00)

Name(s) on the Account: ____

Account Type: __________Checking _________ Savings

ABA Number: ____ ____ ____ ____ ____ ____ ____ ____ ____ (9 digits located in the bottom left corner of check or deposit form. A copy of a voided check (checking) or a letter from the financial institution (savings) must be included with this form to verify banking numbers. We cannot accept a deposit slip or starter check for banking numbers.)

Account Number: _____________________________ (Listed directly after the ABA number at the bottom of the check)

Name of Financial Institution: ____

By signing this Authorization, I acknowledge that my financial institution will process ACH transactions, which may require an ACH deduction prior to the basis selected above, to allow time for processing. I further acknowledge that personal bank fees and/or insufficient fund fees may apply to my individual institution, and I agree to hold LUSP Trust harmless from responsibility for loss or damage due to referenced fees, errors, delays, and/or inaccuracies in transmission.

This authorization will remain in effect unless or until Local Unions Supplemental Pension and Severance Fund Trust receives written notification from me to terminate this authorization in such time and manner as to afford a reasonable opportunity to act on it.

I hereby authorize and direct my employer and/or NEAFCU to withhold allotment specified above and remit to the designated custodial bank. The custodial bank is authorized to accept payments from my employer on my behalf and to deposit such payments into a single consolidated account for transmission to the designated funding agent of the Trust (currently Nationwide Insurance in Columbus, Ohio).

_____________________________________ ________________
Signature of Member Date