

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 (TO BE COMPLETED BY PAYEE)

A NAME OF PAYEE (last, first, middle initial)		D TYPE OF DEPOSITOR ACCOUNT <input checked="" type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	
ADDRESS (street, route, P.O. Box, APO/FPO)		E DEPOSITOR ACCOUNT NUMBER 4375675626	
CITY	STATE	ZIP CODE	F TYPE OF PAYMENT (Check only one) <input type="checkbox"/> Social Security <input type="checkbox"/> Fed Salary/Mil. Civilian Pay <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> Mil. Active <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Mil. Retire. <input type="checkbox"/> Civil Service Retirement (OPM) <input type="checkbox"/> Mil. Survivor <input type="checkbox"/> VA Compensation or Pension <input checked="" type="checkbox"/> Other ALLOTMENT <small>(specify)</small>
TELEPHONE NUMBER AREA CODE			
B NAME OF PERSON(S) ENTITLED TO PAYMENT		G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY (if applicable)	
C CLAIM OR PAYROLL ID NUMBER Prefix Suffix		TYPE SAVINGS ESCROW	AMOUNT \$
PAYEE/JOINT PAYEE CERTIFICATION I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.		JOINT ACCOUNT HOLDERS' CERTIFICATION (optional) I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.	
SIGNATURE x	DATE	SIGNATURE N.A.	DATE
SIGNATURE N.A.	DATE	SIGNATURE N.A.	DATE

SECTION 2 (TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS
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SECTION 3 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

NAME AND ADDRESS OF FINANCIAL INSTITUTION WELLS FARGO BANK P.O. BOX 1786 EUGENE, OR. 97440		ROUTING NUMBER 1 2 1 0 0 0 2 4	CHECK DIGIT 8
		DEPOSITOR ACCOUNT TITLE IFPTE MEMBER	
FINANCIAL INSTITUTION CERTIFICATION I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.			
PRINT OR TYPE REPRESENTATIVE'S NAME Richard Axtell, Vice President	SIGNATURE OF REPRESENTATIVE <i>Richard Axtell</i>	TELEPHONE NUMBER 541-465-5613	DATE 10/22/99.

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

Enrollment Check List

- 1.) Enrollment form selected for the desired plan.
Dental Plan:_____
- 2.) If you have selected the optional vision plan
make sure that is available in your area.
- 3.) Direct deposit 1199A payroll deduction form
filled out and:
 Original copy sent to payroll.
 Copy sent to NWPA
- 4.) Your rates calculated from your selected plan(s)
and your union affiliation and status:
Rates for IFPTE Union member (biweekly): _____
If retired (monthly): _____
Rates for IFPTE Associate member (biweekly): _____
If retired (monthly): _____
- 5.) Remember to check your forms for completeness.
Including:
 - Dentist selected
 - Signed and dated form
- 6.) Your email address: _____
Work Phone# _____
- 7.) Mail all forms, including this checklist to:

Northwest Plan Administrators
1805 Tabor St.
Eugene, OR 97401
<http://www.nffedental.com>