

ILWU-PMA Coastwise Claims Office

PO Box 429101, San Francisco, CA 94142

Fax (415) 801-4092; Tel (800) 955-7376

ILWUPMAWI@zenith-american.com

Weekly Indemnity Electronic Payment Authorization Form

PLEASE NOTIFY THE COASTWISE CLAIMS OFFICE IF THERE ARE ANY CHANGES TO YOUR BANKING INFORMATION

PART A: PAYEE INFORMATION (TO BE FILLED OUT BY PAYEE)

Please Select

Authorization	NEW <input type="checkbox"/>	CHANGE <input type="checkbox"/>	Reg. Number	
Payee (Mbr) Name			Member Phone	
Address				
City		State		Zip
Contact Name <i>(If none put Self)</i>			Phone	
Email Address				

PART B: FINANCIAL INSTITUTION (TO BE FILLED OUT BY PAYEE)

Name of Financial Institution				
Address				
City		State		Zip
Telephone Number			Fax Number	

Please Select Type of Account

Type of Account	CHECKING <input type="checkbox"/>	SAVINGS <input type="checkbox"/>	
Bank Routing No	<hr/> <i>(Must be 9-Digits)</i>		
Account No	<hr/> (Please attach proof of account information so this form can be processed (i.e., a voided check, deposit slip or executed letter from your financial institution written on its letterhead))		

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and account owners. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above. I also confirm the account listed above is FDIC or NCUA insured.

Print or Type Representative's Name	Signature of Representative	Date

I authorize the ILWU-PMA Coastwise Claims Office to deposit by Electronic Funds Transfer (EFT credit entries), funds owed to me into the financial account listed above. This authorization will remain in effect until either party provides written notification of its termination.

Payee Signature _____ Date _____

