

Benefit Payment Services
145 King Street West
Suite 1910
Toronto, ON M5H 1J8
English 1-866-257-2926
French 1-866-484-6863



Northern Trust

ELECTRONIC DEPOSIT AUTHORIZATION FORM

I hereby make the following requests and authorizations relating to my periodic benefit payments from the benefit plan described below: (1) I request and authorize you to initiate credit entries to my Account indicated below; (2) I request and authorize you to initiate debit entries and adjustments for any credit entries made in error to the Account; and (3) I request and authorize the Financial Institution named below to credit and/or debit any such entries to the Account.

(Please print one character in each space allotted – abbreviate if necessary.)

1. COMPANY NAME (FORMER EMPLOYER)

IUPAT CANADA _____

If you receive multiple benefits from Northern Trust, do you want this change to be applied to all plans?

YES (ALL Plans) NO

If 'NO', enter only the valid plan names and plan numbers (if known) to which this change should be applied.

2. PARTICIPANT NAME

(First Name) _____ (Last Name)

3. REFERENCE NUMBER N/A **CLIENT NUMBER 6916** _____

4. PARTICIPANT HOME ADDRESS

ADDR 1 _____

ADDR 2 _____

ADDR 3 _____

ADDR 4 _____

CITY _____ PROV _____ POSTAL CODE _____

5. ACCOUNT TYPE US Checking US Savings Canadian EFT International

6. BANK NUMBER (contact your bank for this number) _____ Transit _____

7. ACCOUNT NUMBER _____ (Canadian / US / International)

8. BANK ID _____ (US / International)

9. COUNTRY _____

I understand that you will verify the information provided above and, in the absence of a discrepancy or other unusual circumstance, will begin the direct deposit of my benefit payments within 30 days of your receipt of this form.

In the event of a discrepancy, I understand that I will be required to provide corrected information by completing a new form.

The authority granted by me on this form is to remain in full force and effect until you have received written notification of its termination in such time and in such manner as to afford you and my Financial Institution a reasonable opportunity to act on it.

I hereby discharge you from all liability whatsoever for any actions taken by you in accordance with the above request and authorization.

PARTICIPANT SIGNATURE _____ DATE _____

Please include a copy of a void cheque and make a copy for your records.

This form is required to be mailed to the address located on the top left hand side of the page.
Do not send to the IUPAT Fund Office.