



COMMUNITY COLLEGE EMPLOYEES BENEFIT TRUST
 c/o DELTA FUND ADMINISTRATORS, LLC
 P.O. BOX 2487 STOCKTON, CA 95201
 PHONE: (800) 700-6762 FAX: (209) 940-5255

AUTOMATIC DEPOSIT AUTHORIZATION

**P L E A S E
R E A D**

Your monthly benefit reimbursement can be credited automatically deposited to the account of your choice, provided the institution is a member of the Automated Clearing House.

To begin the automatic reimbursement deposit service, simply fill out the attached authorization form and return the completed form to Delta Health Systems with a voided check or deposit slip

**PARTICIPANT
INFORMATION**

Name		
Trust Community College Employees Retiree Medical Trust		
Home Phone No.	Cellular No.	E-mail

**BANK
INFORMATION**

NOTE: Your financial institution must be a member of the Automatic Clearing House (ACH). Call your financial institution if you are unsure.	
For deposits to your <u>CHECKING ACCOUNT</u> – attach a voided check which includes your financial institution’s ACH automatic deposit routing number and complete the following.	
Financial Institution Name	
Branch Name	Branch No.
Checking Account No.	Checking Routing No.
For deposits to your <u>SAVINGS ACCOUNT</u> – attach your deposit slip which includes your financial institution routing number and complete the following.	
Financial Institution Name	
Branch Name	Branch No.
Savings Account No.	Savings Routing No.

AUTHORIZATION

I authorize Delta Health Systems to initiate credit entries (deposit) and/or debit entries and adjustments to correct any previous credit which may have been posted in error to my account. This authorization is to remain in full effect until I notify Benefit Trust Administration in writing to cancel this authorization, allowing Benefit Trust Administration a reasonable opportunity to act upon it.

PLEASE PRINT CLEARLY
Name:
Signature:
Date:



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Direct Deposit Instructions

-Should you elect to have your monthly reimbursement deposited into your **checking** account, we ask that you also submit a voided check with your paperwork.

-Should you elect to have your reimbursement deposited into your **savings** account, we ask that you submit a deposit slip with your authorization form.

-Should you not have either a voided check or deposit slip, please feel free to submit a letter from your financial institution verifying your routing number and account number.

Please submit information to our office via mail or fax:

Mailing address:

Delta Fund Administrators
PO Box 2487
Stockton, CA 95201

Fax:

Delta Fund Administrators
209-940-5255

Please feel free to contact our office should you have any questions at (800) 700-6762.

Thank you.