**WEEKLY S.U.B. FUND BENEFIT APPLICATION**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY #: XXX-XX-\_\_\_\_\_\_

CELL PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-MAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHECK ONE:

|  |  |
| --- | --- |
|  | I wish to receive a $150.00 weekly S.U.B. Fund Benefit |

|  |  |
| --- | --- |
|  | I wish to receive a $300.00 weekly S.U.B. Fund Benefit |

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby apply for weekly S.U.B. Fund benefits. I understand that in accordance to the provision of the Plan I must submit a copy of my State’s unemployment statement showing receipt of State unemployment benefits for that week. I understand that the I.R.S. considers any S.U.B. Fund benefit I receive as taxable and that I will receive a W-2 form from the Fund Office for any monies I receive during a calendar year.

Participants Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_

I wish to receive said monies via direct deposit to the account at the financial institution that I have listed within this document. As such, I hereby authorize the Local 697 S.U.B. Fund to initiate credit entries to my account listed below, in the financial institution shown. In the event a credit is made to my account in error, I authorize the Local 697 S.U.B. Fund to make a correcting entry, provided I am notified of the adjustment. This authorization is to remain in effect until the Local 697 S.U.B. Fund has received written notification from me terminating it.

Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**Institution Name**

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**Mailing Address**

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**City State Zip**

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**ABA Routing Number Account Number ○ Checking ○ Savings**

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***DO NOT WRITE BELOW THIS AREA***

Approved: YES NO

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Authorized Fund Signature

Local 697 S.U.B Fund-7200 Mississippi Street, Suite 300, Merrillville, Indiana 46410. (219) 845-4433