

Benefit Payment Consent Authorization

I hereby authorize the release and payment of my benefit to the following account or person as indicated below. I understand this consent allows the relevant agency or institution to process my payment accordingly.

Full Name:

ID/Employee Number:

Account Name (if applicable):

Account Number:

Bank Name:

Relationship to Beneficiary (if not self):

Signature:

Date:

☐ I confirm that the information provided is accurate and I give my consent for this authorization.

Submit