

ELECTRONIC DEPOSIT AUTHORIZATION FORM

I hereby make the following requests and authorizations relating to my periodic benefit payments from the employee 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 NOTE: ALL bank changes MUST have a call back to verify authenticity before they will be processed.**

1. NAME OF PARTICIPANT COMPANY: Oak Ridge National Laboratory

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", please enter ONLY the valid plan names and plan numbers (if known) to which this change should be applied. _____

2. PARTICIPANT NAME: First Name: _____ MI: _____ Last Name: _____

3. SOCIAL SECURITY NUMBER: _____ Phone Number: () _____

4. PARTICIPANT HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

5. ACCOUNT TYPE: ☐ US Checking ☐ US Savings

****Contact the Bank for the following information:**

6. BANK ROUTING NUMBER: _____ ACCOUNT NUMBER: _____

7. ☐ PLEASE CHECK HERE if 100% of this deposit will be transferred to a non-US Bank from the US Bank Account shown above.

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 receipt and phone verification 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 any liability whatsoever for any actions taken by you in accordance with the above request and authorization.

PARTICIPANT SIGNATURE: _____ DATE: _____

Please attach a copy of a VOIDED CHECK – AND – Please retain a copy for your records.