NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS' HEALTH FUND

PO BOX 4002 * EAU CLAIRE WI 54702

TOLL FREE 1 -800-424-3405

PAYMENT OPTIONS FOR RETIREE HEALTH PREMIUM

YOU MUST ELECT ONE OF THE FOLLOWING

Print Name:_____

CITY

ROUTING NUMBER

DEDUCT PREMIUM DIRECTLY FROM PENSION CHECK

I hereby authorize you to deduct my retiree health premium from my monthly pension check, provided the pension check is large enough to cover the deduction. This authorization can only be revoked by notifying the Fund Office in writing.

OR

ELECTRONICALLY DEDUCT PREMIUM FROM BANK ACCOUNT

deduction from my account will take place on the payment due date. Please complete the Authorization Agreement below.

I elect to pay my retiree health premium by an electronic debit directly from my checking or savings account. This

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (ACH DEBIT)

SIGNATURE______SS #__XXX-XX-_____DATE______

SIGNATURE______SS #___XXX-XX-_____DATE

BANK NAME BANK TELEPHONE #

STATE_____ZIP_____

___ ACCOUNT NO_____

PLEASE ATTACH A VOIDED CHECK WITH THE CORRECT BANK ROUTING & ACCOUNT NUMBERS

**Please note: If you elect to have your premium automatically deducted from your HRA, the deduction

on it. This authorization can only be revoked by notifying the Fund Office in writing.

TYPE OF ACCOUNT: CHECKING _____ SAVINGS_____

(REQUIRED)

from your pension check or bank account will start after your HRA is exhausted.

I (we) hereby authorize NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS HEALTH FUND hereinafter called FUND, to initiate debit entries to our account indicated below at the depository named below, hereinafter called DEPOSITORY, to debit the same to such account. This authorization is to remain in full force and effect until FUND has received written notification from us of its termination in such time and in such manner as to afford FUND and DEPOSITORY a reasonable opportunity to act

PARTICIPANT SIGNATURE______SS #__XXX-XX-____DATE_____

(REQUIRED)