

**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**

*(Please elect one of the following)*

Print Name: \_\_\_\_\_

**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.*

PARTICIPANT SIGNATURE \_\_\_\_\_ SS # \_\_\_XXX-XX-\_\_\_\_\_ DATE \_\_\_\_\_

**OR**

**ELECTRONICALLY DEDUCT PREMIUM FROM BANK ACCOUNT**

\_\_\_\_\_ I elect to pay my retiree health premium by an electronic debit directly from my checking or savings account. This deduction from my account will take place on the payment due date. Please complete the Authorization Agreement below. Electronic transfers are set up on a quarterly basis at least one month before the first withdrawal is made. *The first withdrawal must occur for payment of the first month of a quarter. Eligibility quarters begin February, May, August and November.*

**AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (ACH DEBIT)**

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

SIGNATURE \_\_\_\_\_ SS # \_\_\_XXX-XX-\_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ SS # \_\_\_XXX-XX-\_\_\_\_\_ DATE \_\_\_\_\_

BANK NAME \_\_\_\_\_ BANK TELEPHONE # \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TYPE OF ACCOUNT: CHECKING \_\_\_\_\_ SAVINGS \_\_\_\_\_

ROUTING NUMBER \_\_\_\_\_ ACCOUNT NO \_\_\_\_\_

*(REQUIRED)*

*(REQUIRED)*

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

**\*\*PAYMENT IS DEDUCTED ON A MONTHLY BASIS FROM YOUR BANK ACCOUNT**