Automatic Deduction for Monthly Retiree Self Payment Form

The BEST way to pay your monthly healthcare premium payment….

And here's why…

Automatic deduction is safe because your monthly Retiree self-payment is *automatically deducted from your bank account* – no more worrying about lost or stolen checks or delays caused by mail service.

Automatic deduction is free! Deducting your payments from your bank account eliminates the cost of using personal checks and stamps.

Automatic deduction is easy because your Retiree self-payment is deducted from your checking or savings account on time, correctly and confidentially. **No more worries about termination of your healthcare for late or lost checks.**

After completion it will take the Benefit Office about 30 days to process your automatic payment enrollment. Until your enrollment is complete, you will continue to receive monthly self-payment statements to remind you that your self-payment is due.

We have enclosed a self-addressed envelope for your convenience. You may also fax your completed form to (xxx) xxx-xxxx.

Physical Address: 5295 South Commerce Drive, Suite 220 • Murray, UT 84017
Mailing Address: P.O. Box 30751 • Salt Lake City, UT 87130-0751
Toll Free: 844-989-2321
www.8thDistrictBenefits.org

EIGHTH DISTRICT ELECTRICAL FRINGE BENEFIT FUND
BANK ACCOUNT
SELF PAYMENT AUTO DEDUCTION AGREEMENT

Name of Participant_____Social Security No _____

Address _____

City_____State_____Zip_____

Telephone No ( ) _____

Bank Account Information *– Attach a voided check from your account and/or complete the information below. See sample check at the bottom of the page for help completing this section. DO NOT attach a deposit slip.*

Routing No. ☐☐☐☐☐☐☐☐☐ Account No._____

Type of Account: ☐ Checking ☐ Savings

Financial Institution

Name _____

Address_____

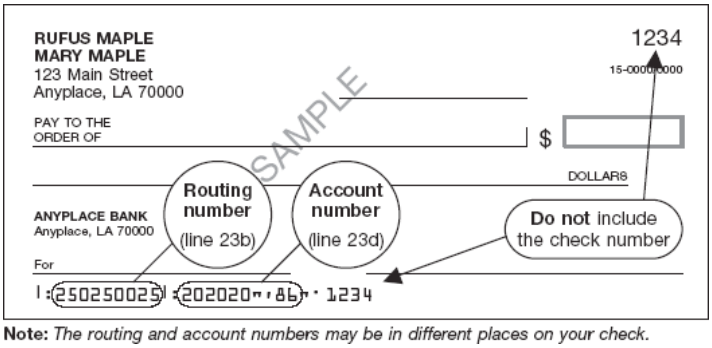
City_____State_____Zip_____

Telephone Number _____

I, the undersigned, hereby authorize the Eighth District Electrical Fringe Benefit Fund to deduct all amounts required under the Fund to continue my healthcare coverage from my bank account at the Financial Institution named above. **I understand that the required payment will be deducted from the account indicated above on or around the 10th of each month.** This authorization shall remain in force until I revoke it in writing or until my death, whichever occurs first. If at any time the Fund should credit my account for a benefit to which I am not entitled, I authorize and direct the Financial Institution to refund the Fund.

_____ _____

Signature **Date**



Note: *The routing and account numbers may be in different places on your check.*