

# *All Alaska Longshore Health & Welfare Trust*

## AutoPay Application Form

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

(Please Print)

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

I authorize BeneSys Inc. Plan Administrators to begin automatic deduction from my account with the financial institution (bank) named below:

Checking Account

Savings Account

Bank Name: \_\_\_\_\_

Name(s) on Account:

\_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Bank ABA Routing Number: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This authorization shall remain in effect until canceled.

**Don't forget to include a voided blank check  
with this application form.**