BAC of Michigan Health and Welfare Fund

P.O. Box 99490, Troy, Michigan 48099-9490
(248)828-6000 or (800)435-4080

Health and Welfare Fund
Monthly Self-Pay Automatic Deduction Form

Name of Participant_____ Subscriber ID#_____

Address_____

City _____State _____Zip_____

Telephone Number _____

BANKING INFORMATION The bank that you specify must be a member of the Automated Clearing House. Most banks are, and yours probably is, but if not, they will let you know what alternatives are available.

I request that my Insurance Fund Self-Payment be Electronically Transferred from my :

(Please Choose One) Checking Account_____Savings Account_____

FINANCIAL INSTITUTION INFORMATION

Bank Name _____

Street _____

City_____ State _____ Zip Code _____

Your Account Number_____

ABA Number (Bank I.D. Number) _____

Please provide a VOIDED copy of your check

YOUR AUTHORIZATION
I hereby authorize BAC of Michigan Health and Welfare Fund Office, to initiate debit entries from my account indicated above. If an amount should be debited from my account in error or after my death, I authorize the appropriate credit adjustment to be made to my account.

Participant Signature: _____Date:_____

Additional Signature:_____ Date:_____
(If joint account BOTH persons must sign this authorization)