HARRISON TRUST
A Family Health Plan
www.harrison.aibpa.com

Harrison Health & Welfare Retiree

Edison Pension Premium Deduction Form

Completed Forms should be forward to: Harrison Electrical Workers Trust Fund
PMB#116,
5331 S Macadam Ste 258
Portland OR 97239

Questions? Call (503) 224-0048 or (800) 547-4457, Ext. 1679

Name:______________________________ **SS#:**________________________
(Please Print)

Address:__________________________________ **Phone:** (____)____________

City:______________________ **State:**__________ **Zip:**____________

I authorize Edison Pension to deduct the monthly Harrison Trust Health & Welfare Retiree Plan premium from my monthly Edison Pension Check. I understand the premium amount will be deducted from monthly pension check for the next month's coverage.

Premium Deduction for: ________ Self Only ________ Self & Spouse (enter spouse's name below)

If you selected Self & Spouse, list spouse name ____

Retiree Signature:____Date:____________________

This authorization shall remain in effect until canceled by me in writing.

For Plan Administrator Use only:

Beg. Date _________________ **Amount$**________________

CSR ________________________________ **Date**______________________