NECA IBEW
LEADING THE ELECTRICAL INDUSTRY

HARRISON TRUST

A FAMILY HEALTH PLAN
WWW.HARRISONBENEFITS.ORG

Harrison Health & Welfare Domestic Partner Auto-Pay Application Form

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

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

A voided blank check must accompany this application form.

Name:_____ **SS#:**_____
(Please Print)

Address:_____ **Phone: (____)**_____

City:_____ **State:**_____ **Zip:**_____

I authorize the Harrison Electrical Workers Trust Fund to initiate deductions from my account as listed below and to apply the funds as my monthly Harrison Trust Health & Welfare premium cost for domestic partner coverage:

☐ Checking Account ☐ Savings Account

Bank Name:_____

Name(s) on Account:_____

Bank Account Number:_____

Bank ABA Routing Number (9-digits):_____

Authorized Signature:_____ Date:_____

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

For Plan Administrator Use only:

Beg. Date _____ **Amount $**_____

CSR _____ **Date**_____

Application forms are due by the 1st of the month for the following month's payment to be made via Autopay