



United Brotherhood of Carpenters and Joiners of America
General Office and Staff
Health & Welfare Plan

**The United Brotherhood of Carpenters and Joiners of America General Office and Staff Trust Funds
Automatic Pension Deduction for Monthly Retiree Self Payment Form**

**The BEST way to pay your
Monthly healthcare premium payment....**

And here's why...

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

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

Please take a few minutes and complete the form on the back so you can take advantage of the benefits of automatic pension self-payment deduction. It will take the Benefit Office about 30 days after it receives your authorization to set up the procedure with your bank. Please be assured there will be no interruption in your healthcare benefits and there is no cost to you.

Mail to:

The United Brotherhood of Carpenters and Joiners of America General Office and Staff
Health & Welfare Plan
P.O. Box 400008
Las Vegas, NV 89140
Phone 855-550-1696 • Fax 702-257-5361



United Brotherhood of Carpenters and Joiners of America

General Office and Staff Health & Welfare Plan

SELF PAYMENT PENSION DEDUCTION AGREEMENT

Name of Participant: _____ Social Security No: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No: () _____ Email: _____

I, the undersigned, am receiving a monthly benefit from the The United Brotherhood of Carpenters and Joiners of America General Office and Staff Pension Plan and wish to have a portion of that benefit used to maintain eligibility for benefits under the The United Brotherhood of Carpenters and Joiners of America General Office and Staff Health & Welfare Plan for the coverage which I have selected. For that purpose, I hereby assign whatever amount may be required from time to time to maintain that coverage under the Health and Welfare Fund as reported to the Pension Fund by the Health and Welfare Plan and authorize the Pension Fund to deduct that amount from my monthly benefit check and remit it directly to the Health and Welfare Plan.

I understand that I may rescind this authorization at any time by notifying the Pension Fund Office, in writing, at least sixty days before the effective date of the rescission.

Signature: _____ Date: _____