CMTA-IAM JOINT RETIREE HEALTH & WELFARE PLAN

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Authorization Agreement for Automatic Payments for Retiree Health Care Coverage

I hereby authorize the CMTA-IAM Joint Retiree Health Plan (Health Plan) to initiate debit entries to my:

(Select ONE)

☐ Checking Account OR ☐ Savings/Other Account*
If Checking account selected, attach copy of voided check to ensure that the banking information is correctly processed.

I acknowledge the origination of Automatic Payment transactions to my account must comply with U.S. law. I understand that at the present time, the amount of each scheduled payment to be debited is **$** _____ (if amount is not entered, please enter the amount of your current retiree self-payment) and this debit will be made on or after the 10th day of each month following confirmation of the effective date by the Trust Fund Office. I understand that my retiree self-payment amount may change based on Plan rules as determined by the Board of Trustees of the CMTA-IAM Joint Retiree Health & Welfare Trust Fund and that the Trust Fund will advise me of any change in that amount or in the day of the month, and will do so before such change is made.

This authorization is to remain in full force and in effect until the Health Plan has received written notification from me of its termination in such time and in such manner as to allow the Health Plan reasonable opportunity to act. I authorize said financial institution to notify the Health Plan of any payments that become due after my death. I also understand that I will notify the Health Plan in writing of any change in my residential address. I understand that I must sign a new authorization if my account number changes for any reason.

Name: _____ **Social Security No.** **XXX-XX-** _____
Please Print (Last, First) **Enter only the last four (4) numbers**

Daytime Telephone: ( ) _____ **Cell: ( )** _____

Signature: _____ **Date:** _____

If you do not elect a checking account, please complete the banking data below to initiate the debit:

*Bank: _____
Name Address Telephone No.

Routing Number: _____ Account Number: _____

TRUST FUND OFFICE USE ONLY

Confirmation of Automatic Payment Authorization

Effective: _____ Coverage Month: _____ Amount: $ _____