MID CENTRAL OPERATING ENGINEERS
HEALTH AND WELFARE FUND

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBIT)

New authorization ☐ Cancel authorization ☐ Changes ☐

Fund Name Mid Central Operating Engineers Health and Welfare Fund (herein referred to as "Fund")
Address P. O. Box 9605, Terre Haute, IN 47808
Fund ID Number 35-0917610

I (we) hereby authorize Fund to initiate debit entries to my (our)

(Select one) **___ Checking Account**
___ Savings Account

Please debit my (our) account for Retiree prmium by the **Benefit Period (April, August & December**).

Indicated below at the depository financial institution named below, hereinafter called BANK, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U. S. Law.

Bank Name _____
Street Address _____
(from front of check or deposit slip)
City _____ State_____ Zip_____

Routing Number_____ Account Number _____ Bank Phone #_____
(located in the lower left hand corner of your check, usually the first 9 digits. Contact your bank if you need help)

I (we) certify that the information I (we) provided is correct and that I (we) are the authorized signer or designate of the account provided for direct withdrawal transactions and am entitled to provide this authorization. This authorization is to remain in full force and effect until FUND has received written notification from me (or either of us) of its termination in such time and in such manner as to afford FUND and BANK a reasonable opportunity to act on it. I (we) authorize Fund to adjust debit amount due to increase/decrease in self-payment amount or due to statues change.

Signature _____ Date _____
Printed Name _____ SS#_____

Signature _____ Date _____
Printed Name _____ SS# _____

ACCOUNT HOLDER IS REQUIRED TO VERIFY BANK ACCOUNT DATA AND ATTACH A VOIDED CHECK HERE