

School District No. 1 Health and Welfare Trust

A contribution method known as Electronic Funds Transfer is available to individuals (and spouses) participating in the School District No. 1 Health and Welfare Trust. With the Electronic Funds Transfer system, you can elect to have the amount of your monthly contribution automatically deducted from your bank account on the fifth (15th) of each month. You will no longer receive a monthly billing from the Trust Office; the amount of the deduction will be listed on your monthly bank statement with the notation "SCHOOL DIST 1 INS PREM."

In order to participate in Electronic Funds Transfer, you must have a checking or savings account, and this authorization form must be signed and returned to the School District No. 1 Health and Welfare Trust at the address below. **YOUR FIRST PAYMENT TO THE SCHOOL DISTRICT NO. 1 HEALTH AND WELFARE TRUST MUST BE MADE VIA PERSONAL CHECK/MONEY ORDER/CASHIER'S CHECK.** Your electronic payment will then be set-up to begin for payment of the following month.

After electing Electronic Funds Transfer, you will receive confirmation of the exact amount of the monthly deduction and the effective month of the deduction. You should continue to make your monthly contributions until the effective month listed in your confirmation letter. If you have prepaid for your health and welfare coverage, you may still elect Electronic Funds Transfer. It will become effective the month following the last month of your prepaid contribution.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION AGREEMENT

I (we) authorize the School District No. 1 Health and Welfare Trust ("Trust") to deduct payment for any amounts owing by me (us) to Trust as such amounts become due by initiating debit entries of a variable amount (current rate in effect for type of coverage elected) to my (our) bank account indicated below in the Financial Institution named below, and I (we) authorize Financial Institution to accept any debit entries initiated by Trust to such account.

Financial Institution _____ Bank _____

Address _____ City _____ State _____ Zip _____

(Please attach a voided check with bank routing number) _____ Bank Routing # _____ Bank Account # _____

Type of Account	
<input type="checkbox"/>	Checking
<input type="checkbox"/>	Savings

This authority is to remain in effect until Trust has received written notification from me (us) of its termination. I (we) understand that I (we) have the right to stop payment of a debit entry by notification to Trust prior to charging account. Also, after the account has been charged, that I (we) have the right to have the amount of any erroneous debits immediately credited to my (our) account by Financial Institution up to fifteen (15) days following issuance of statement or forty-five (45) days after the account is charged, whichever occurs first.

Participant's Name (*Print*) _____ Social Security No. _____

Address _____ Street _____ City _____ State _____ Zip _____

Date _____ Signed _____ Participant Phone No. _____

Date _____ Signed _____ Spouse (if joint bank account)

Please return this form to:

SCHOOL DISTRICT NO. 1 HEALTH AND WELFARE TRUST
700 NE Multnomah St., Ste. 350
Portland, OR 97232-4197
(844) 203-0239