ELECTRONIC FUNDS TRANSFER

HEALTH & WELFARE TRUST
SCHOOL DISTRICT NO.1

SCHOOL DISTRICT NO. 1 HEALTH AND WELFARE TRUST

A contribution method known as Electronic Funds Transfer is available to individuals (and spouses/domestic partners) 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 benefit contribution automatically deducted from your bank account. 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. **IMPORTANT NOTE: The amount of your monthly contribution will be automatically deducted from your bank account on the fifth (5th) of each month**.

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 the following month. If you have prepaid 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 ("the Trust") to deduct payment for any amounts owing by me (us) to the 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 the Financial Institution to accept any debit entries initiated by the Trust to such account.

Financial Institution/Bank

Type of Account
❑ Checking ❑ Savings

Address

City

State

Zip

Bank Routing #

Bank Account #

PLEASE ATTACH A VOIDED CHECK WITH BANK ROUTING NUMBER AND ACCOUNT NUMBER

This authority is to remain in effect until the 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 the Trust prior to charging my (our) 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 the Financial Institution up to fifteen (15) days following issuance of statement or forty-five (45) days after the account is charged, whichever occurs first.

Name (Print)

Social Security No.

Address

City

State

Zip

Phone No.

Date

Signed

Date

Signed Spouse (if joint bank account)

Please return this form to:
SCHOOL DISTRICT NO. 1 HEALTH AND WELFARE TRUST
12205 SW Tualatin Rd., Suite 200 • Tualatin, OR 97062
833-255-4123 (toll-free) or 503-486-2107