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AUTHORIZATION AGREEMENT
FOR AUTOMATIC WITHDRAWAL OF HEALTH PLAN PREMIUMS
BY ELECTRONIC FUND TRANSFER

I hereby authorize the NECA/IBEW Family Medical Care Plan ("Fund"), to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my account as described below at the financial institution name below:

Name of Financial Institution: (Bank)_____

Address_____

City:_____STATE:_____ZIP:_____

PLEASE ATTACH A VOIDED CHECK SO WE CAN VERIFY THE FOLLOWING;

Transit / ABA No.:_____

Account Type: (Circle One) Checking Savings

Account Number:_____

This authorization is to remain or will remain in full force and effective until the Fund has received written notification from me of its termination in such time and in such manner as to afford the Fund and Bank a reasonable opportunity to act on it.

_____
Signature of Retiree

_____ _____
Social Security Number Phone Number

_____
Date

NOTE: Changes affecting electronic transfers must be received in the Fund Office no later than the 15th of the month in order to be effective the first of the following month.

Remember to keep Fund Office advised of your correct mailing address for correspondence purposes.