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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: \_\_\_\_\_ STAT: \_\_\_\_\_ 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 to remain in full force and effect 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 15<sup>th</sup> 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.