# Self-Payment Authorization Form

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Reset

**St. Louis - Kansas City Carpenters Regional Health Plan (Plan)**
**Benefit Plans Office - 1419 Hampton Avenue - St. Louis, MO 63139**
**Phone: (314) 644-4802| Toll-Free: (877) 232-3863 | Fax: (314) 678-1110 | Email: benefits@carpdc.org**

carpenters' benefit plans
HEALTH & RETIREMENT SERVICES

Member Name:

Last 4 Digits of Member SSN:

Please complete the form and return it to the Carpenters' Benefit Plans Office. **Note:** ***You will need to continue paying your monthly premiums until you receive verification from our office confirming your automatic payment effective date***.

To the Trustees of the St. Louis - Kansas City Carpenters Regional Health Plan (Plan), I hereby request that my health and welfare contributions, payable by me, be processed through the following Payment Option:

## Please select ONLY ONE Payment Option

## Option 1 - ☐ Deduct from my Pension Benefit (Preferred Method)

What Plan is your pension benefit from: ◯ St. Louis ◯ Kansas City

Net Monthly Pension Amount* (after income tax and union dues deductions, if applicable): $ _____

*Net Monthly Pension Amount must be equal to or greater than requested premium amount.

***(Note: If you have a Geneva or a KBT Pension or are a COBRA participant, this option is not available to you.)***

## Option 2 - ☐ Debit from bank account: ◯ Checking Account ◯ Savings Account

Attach a voided check

Use account information from your statement not your deposit slip

Name of Financial Institution:

Transit Routing Number:

City and State of Financial Institution:

Bank Account Number:

## Option 3 - ☐ Auto Pay from Credit Card: ◯ **Master Card** ◯ **Visa** ◯ **Discover**

Credit Card Account Number:

Expiration Date:

Printed Name of Card Holder:

Signature of Card Holder:

I understand the Trustees have discretion whether to comply with this request. I understand I may cancel or change this authorization for payment from the account selected above by written notice to the Plan at least ten days prior to the first day of the month for that month's payment processing. I certify this authorization will remain in effect until either (1) I provide written notice to cancel this request, or, in the case I have elected Pension Deduction above, (2) my health and welfare benefit is greater than my pension benefit and therefore pension deduction is no longer possible. My signature on this authorization indicates that I authorize the verification of the above information by the financial institution of the Plans' Trustees or their designated representative. I consent that a copy of this authorization may be considered as valid as the original.

I also understand the date the deduction will begin and the current rate will be verified with the Benefit Plans Office. Also, Option #1 is not possible if Health and Welfare contribution exceeds monthly Pension Benefit.

Sign Here

Member Signature:

Date:

If you have any questions, please contact the Carpenters' Member Services Department:

## For Office Use Only

Rate Type:

Amount:

Pymt Effective Date:

Auth By & Date:



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