IAFF Health & Wellness Trust

Monthly Premium Deduction - ACH Authorization

This form is required to have monthly benefit premiums deducted from your checking or savings account. Payments are finalized on the 15th of the month; processing times vary depending on the financial institution.

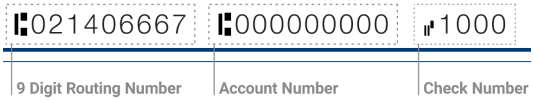
Account Holder Name _____

Phone Number _____ Email _____

Please provide your full account and routing number. This information can be obtained from your bank or the bottom of a current check, as shown below.

Account Number _____

Routing Number _____



☐ Checking ☐ Savings

Subscriber name, if different _____

Monthly Premium Amount $_____

I authorize IAFF Health & Wellness Trust to process payment as outlined above, as well as subsequent payments for the balance due, until such time that I notify the Trust office in writing of any necessary changes or cancellations. I understand that my deductions may be automatically increased or decreased for any changes in premiums that I am required to pay for the coverage elected by the subscriber.

Account Holder Signature _____ Date_____

Please return form to the Trust Office at:
IAFF Health & Wellness Trust
P.O. Box 6
Mukilteo, WA 98275

Phone: 206-859-2678 Fax: 866-676-1530 Email: IAFFHealthTrust@vimly.com