IAFF Health & Wellness Trust | MAGNACARE℠
PO BOX 3582, SEATTLE | WA 98124-35820

IAFF ACH Debit Authorization Agreement

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

☐ IAFF Health & Wellness Trust (herein referred to as the "Trust") Bank Company ID: _____

I (we) hereby authorize the Trust to initiate debit entries to my (our):

☐ Checking Account ☐ Savings Account ***(select one)***

Please debit my (our) account for employer contributions, premium payments, self-pay amounts, retiree contributions, and/or other amounts due to the Trust.

Depository Name _____

City _____ State _____ Zip Code _____

Routing Number _____ Account Number _____

This authorization is to remain in full force and effect until the Trust has received written notification of termination in such time and manner as to afford the Trust and the Depository a reasonable opportunity to act on it.

Depositor Name _____

Signature _____ Date _____

Name _____ Title _____

Depositor Name _____

Signature _____ Date _____

Name _____ Title _____

Bank Account Verification Required

Account holder is required to verify bank account information for initial setup or future account changes by attaching one of the following:

- Voided check
- Bank account verification letter showing full routing and account number
- Direct deposit verification form or similar banking documentation showing full routing and account number

Submission Instructions

- Please submit the completed form and supporting banking documentation using the approved IAFF secure submission process.
- Secure submission method email: **IAFF-Finance@MagnaCare.com**
- *Do not send cash. Do not submit banking information by standard email unless explicitly directed through an approved process.*

For Internal Use Only

Date Received	Reviewed By	Processing Notes