Monthly Premium Deduction - ACH Authorization

IAFF Health & Wellness Trust | MAGNACARE™

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 _____

Full Monthly Premium Amount

☐ Yes ☐ No If No, please specify the 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:

Email: iaff.eet@magnacare.com

Mail: IAFF HEALTH & WELLNESS TRUST
PO BOX 3582
SEATTLE WA 98124-3582

When returning this form, please ensure that you provide a voided check, or a clear image of a check showing your routing number and account number.

Questions? Email Customer Service at **IAFFHealthMember@magnacare.com** or call us at **1-877-624-6219,** Monday–Friday, 9:00 AM – 9:00 PM ET (6:00 AM – 6:00 PM PT).