Self-Payment Authorization Form

Reset

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

Participant Name (Last, First, Middle Initial)	Last 4-digits of SSN

Please complete this form and return it to the address at the top of this form. **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 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: **MasterCard** ☐ **Visa** ☐ **Discover** ☐

Credit Card Account Number	Expiration Date
Printed Name of Card Holder	Signature of Card Holder

I understand that 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 Plan's 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.

Participant Signature:_____ Date:_____

For Office Use Only

Rate Type	Amount	Pymt Effective Date	Auth By & Date