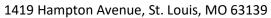
Self-Payment Authorization Form

St. Louis – Kansas City Carpenters Regional Health Plan



Phone: (314) 644-4802 | Toll-Free: (877) 232-3863 | Fax: (314) 678-1110 | Email: benefits@laborfunds.org

CADDENTEDS
CARPENTERS
BENEFIT PLANS HEALTH 8 RETIREMENT SERVICES

Participant Name (Last, First, Middle	Initial)		Last 4-digits of SSN			
·	d return it to the address at the receive verification from our of	•				
	is – Kansas City Carpenters Regi e by me, be processed through			y request that my health and		
	Please select ONLY	ONE Payment	Option			
Option 1 - Deduct	from my Pension Benefit (Pr	eferred 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 Ge	eneva or KBT Pension or are o	a COBRA participa	nt, this op	tion is not available to you.		
Option 2 - Debit fr	rom bank account: Checking A		Account	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: Date:						
For Office Use Only						
Rate Type	Amount	Pymt Effective Date		Auth By & Date		