Self-Payment Authorization Form

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

Reset

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

To the Trustees of the Mid-America Carpenters Regional Council Health Plan (Plan), I hereby request that my health and welfare contributions, payable by me, be processed through the following payment option:

Payment Options

Option 1 – Member Portal

Follow the instructions provided. *No selection on this form necessary.*

To set up a recurring payment using your bank account or credit card, please set up an account/sign into our Member Portal at **laborfunds.org /member-portal** or scan the QR code on the right.

Please note: *If you wish to use a credit card for recurring payments, using the Member Portal is your only option.*

Option 2 – Pension Benefit Deduction (Preferred Method):

To set up a recurring payment using your pension benefit deduction or bank account, complete this section and mail this form to the address at the top of this form. **Manual Payments will need to be made until Pension Deduction is confrimed.**

Continue to pay your monthly premiums until you receive confirmation of your automatic payment effective date.

☐ **Pension Benefit Deduction** (Preferred Method) ☐ St Louis Plan ☐ Kansas City Plan

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 3 – Bank Account Deduction (By Phone):

If you wish to set up recurring payment using your bank account and do not wish to use the Member Portal, please contact The Benefits Office for assistance.

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 #2 is not possible if Health and Welfare contribution exceeds monthly Pension Benefit.

Participant Signature:_____ Date:_____

For Office Use Only

Rate Type	Amount	Payment Effective Date	Auth By & Date