MICHIGAN BAC HEALTH CARE FUND
DIRECT DEBIT AUTHORIZATION AGREEMENT

I (we) hereby authorize the Michigan BAC Health Care Fund to instruct my Financial Institution to make monthly Retiree Self-Payments to the Fund from the Account identified below on or around the 25th of each calendar month. This authority will remain in effect until The Fund has received, by the 15th of the month, my (our) written notification that I (we) have terminated this authorization or until the Fund has mailed to me, written notice of termination of this agreement. I agree and understand that the amount of my Account Debit will change automatically if my (our) self-payment rate changes at any time.

CONTACT INFORMATION

Name(s) on Account:_____

Daytime Phone #: _____ Other Phone #: _____

Address: _____

_____

Other Address:_____

_____

Member ID or SS Number.: _____

Member Signature: _____ Date:_____

Alternate Signature if Joint Account*:_____ Date:_____

*If more than one name appears on the account to be debited, both parties must sign the authorization form.

REQUIRED FINANCIAL INSTITUTION INFORMATION

(A Voided Check or Savings Deposit Slip must accompany this form)

Name of Financial Institution: _____

Account Type (choose one): ☐ Checking ☐ Savings

Account Number: _____

Transit Routing Number: _____

(This number is located in the lower left corner of your check)

PLEASE NOTE: COMPLETED FORMS MUST BE RECEIVED BY THE FUND OFFICE NO LATER THAN THE 20TH OF EACH MONTH. PAYMENTS WILL BE DEDUCTED FROM YOUR ACCOUNT THEREAFTER ON OR THE LAST BUSINESS DAY THAT FALLS ON OR PRECEEDS THE 25TH OF EACH MONTH.

PLEASE RETURN YOUR COMPLETED FORM WITH A VOIDED CHECK OR SAVINGS DEPOSIT TICKET TO THE ADDRESS LISTED BELOW:

Michigan BAC Health Care Fund
6525 Centurion Drive
Lansing, Michigan 48917-9275

FOR OFFICE USE ONLY

Debit Effective Date: _____ Debit Amount: $_____

For questions, contact the Customer Service Department of the MI BAC Health Care Fund (800) 531-2244