

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

14 NEW ENGLAND EXECUTIVE PARK • SUITE 200
BURLINGTON, MASSACHUSETTS 01803-5201
TELEPHONE (781) 272-1000 • TOLL FREE (800) 342-3792 • FAX (781) 238-0703

**AUTHORIZATION AGREEMENT FOR WITHDRAWAL
FOR C.O.B.R.A. RETIREE SELF-PAY MONTHLY PREMIUMS**

I/we hereby authorize the Massachusetts Laborers' Health and Welfare Fund, hereinafter called the "Fund", to initiate credit/debit entries to my/our () Checking () Savings account (please select one) indicated below at the depository financial institution named below, hereinafter called "Bank", and to credit/debit the same to such account.

NAME OF BANK _____ BRANCH _____
CITY _____ STATE _____ ZIP CODE _____
ROUTING # _____ ACCOUNT # _____

Please furnish a voided check for verification of the above information

This authorization is to remain in full force and effect until the "Fund" has received written notification from me/us of its termination in such time and in such manner as to afford the "Fund" and "Bank" reasonable opportunity to act on it.

NAME _____ NAME _____
(PLEASE PRINT) (PLEASE PRINT)

SOCIAL SECURITY #: _____ SOCIAL SECURITY #: _____

SIGNED _____ SIGNED _____

DATE _____ DATE _____

NOTE: All written credit/debit authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization, no later than the 15th day of the month preceding the month the payment would be applied. Any declined or insufficient funds are subject to a \$25.00 fee.

*IF A JOINT ACCOUNT IS BEING USED, BOTH PARTIES MUST SIGN AND DATE THIS FORM.

Este aviso está disponible en español en el sitio de web www.mlb.org