HARRISON TRUST

A Family Health Plan

www.harrison.aibpa.com

Harrison Health & Welfare Domestic Partner Auto-Pay Application Form

Completed Forms should be forward to: Harrison Electrical Workers Trust Fund
1220 SW Morrison St., Suite 300
Portland OR 97205

Questions? Call (503) 224-0048 or (800) 547-4457, Ext. 1679

A voided blank check MUST accompany this application form. If we do not receive a voided check the Domestic Partner cannot be enrolled in the plan.

Name:______________________________ **SS#:**______________________________
(Please Print)

Address:______________________________ **Phone:** (____)______________

City:____________________ **State:**______________ **Zip:**______________

I authorize the Harrison Electrical Workers Trust Fund to initiate deductions from my account as listed below and to apply the funds as my monthly Harrison Trust Health & Welfare premium cost for domestic partner coverage:

☐ Checking Account ☐ Savings Account

Bank Name:____

Name(s) on Account:______________________________________

Bank Account Number:_____________________________________

Bank ABA Routing Number (9-digits):_______________________

Authorized Signature:__________________________Date:____________________

This authorization shall remain in effect until canceled by me in writing.

For Plan Administrator Use only:

Beg. Date ________________ **Amount** $______________

CSR ______________________________ **Date**____________________

Administered by A&I Benefit Plan Administrators, Inc.
1220 SW Morrison St., Suite 300, Portland, OR 97205-2222
(503) 224-0048 (800) 547-4457 Fax (503) 228-0149