



**TRANSIT EMPLOYEES' HEALTH AND WELFARE PLAN**  
 2701 Whitney Place #100  
 Forestville, Maryland 20747  
 P: 301-568-2294 F: 240-745-3956 E: INFO@TEHW.ORG

**AUTOMATIC DEBIT AUTHORIZATION AGREEMENT**

*This agreement is used to authorize the electronic transfer of funds from your bank account to the Transit Employees' Health & Welfare Fund. Please check the boxes below.*

New Automatic Debit Request     Change Debit Request     Cancel Debit Request  
 Type of Account:                       Checking                       Savings

Name: \_\_\_\_\_ Employee #: \_\_\_\_\_

Address: \_\_\_\_\_

Apt/Building #: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Bank Institution Name: \_\_\_\_\_

Bank Institution Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Account Number: \_\_\_\_\_

Routing Number: \_\_\_\_\_

*By signing this form, I authorize the Transit Employees' Health and Welfare Fund (Fund) to debit any health and welfare premiums from the bank account above (Account) to maintain my Fund health coverage. I acknowledge this authorization will remain in effect until the Fund receives written notification to terminate the Fund health coverage. I agree that if the account is insufficient to pay the entire premium due, or if I received services after this authorization is revoked and the premium was not paid, the Fund will terminate my coverage immediately without further notice. I further agree that I am responsible to pay any unpaid premiums, fees, penalties, collection costs or other damages associated with my failure to pay any premium owed to the Fund in a timely manner.*

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Payments will be deducted automatically from the designated account by the 15th of the month. However, if the 15th falls on a weekend or bank holiday, the deduction will occur on the business day prior to the 15th of the month. In some cases, processing times will be delayed until the next business day.*



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Mail this original agreement with a voided check to:

Transit Employees' Health & Welfare Fund  
2701 Whitney Place, Suite 100 Forestville, MD 20747

Fax Number: 240-745-3956

**EXAMPLE OF VOIDED CHECK**

