Hanford Employee Welfare Trust (HEWT)

DIRECT PAYMENT PLAN AUTHORIZATION FORM

Payroll Number:	Participant's Name *(please print)*:	Social Security Number:

This form authorizes the HEWT to automatically deduct all of my required insurance contributions from the account identified below. This authorization will remain in effect until I provide written cancellation. Forms must be received by the first of a month to be effective the first of the following month, or automatic withdrawal will be delayed an additional month.

INSTRUCTIONS:

1. Check the type of account you would like to have your payment deducted from *(checking or savings)*.
2. Provide the financial institution information and your participant information.
3. Attach a copy of a voided check for verification of all financial institution information. If you are unable to attach the voided check, please provide your account and routing numbers.
4. *PLEASE BE SURE TO SIGN THE COMPLETED FORM* and return to the address listed below.

ACCOUNT INFORMATION:

☐ Checking Account ☐ Savings Account

Please Print:

Financial Institution Name: _____

Financial Institution Address: _____

Account Number: _____

Routing/Transit Number: _____

(Also referred to as RTN, Routing Transit Number, ABA, or bank routing number, your routing number is typically a nine-digit numeric code printed on the bottom of checks. If you are unsure which number to use, please contact your Financial Institution).

Please Print:

Participant's Mailing Address *(Street, City, State, Zip)*:

_____

_____

Participant's Phone Number: _____ Email Address: _____

I understand I will receive a notice if the amount changes. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with the provisions of Washington State and U. S. law. I authorize Hanford Mission Integration Solutions (HMIS) or its assignee on behalf of the HEWT to initiate electronic debit entries, in the full amount due, from the account.

Participant:

_____ _____

Print First and Last Name *Signature / Date*

Please return completed form to: HMIS, Attn: Benefits Accounting
PO Box 943, H3-08
Richland, WA 99352

Submit by Email

Please keep a copy of the completed authorization for your records.

OFFICIAL USE ONLY (when filled in)