



AUTHORIZATION FOR DIRECT WITHDRAWAL

Company Name

Tax ID Number

Street Address

City State Zip

Mailing Address

City State Zip

Contact Name

Phone Number

Name of Financial Institution

Bank **Credit Union**

 Checking **Savings**

Account Number

Routing Number

This authorization will remain in effect with the Washington Farm Bureau Healthcare Trust until cancelled by written notification from a designated officer at the company stated above is received.

You will need to inform your bank listed above that a withdrawal is acceptable and a maximum amount limit can be established if you so choose. Washington Farm Bureau Healthcare Trust will pull funds on the first business day of the month equal to the amount invoiced to you around the previous 5th of the month. If enrollment changes are made after the invoice is generated, those adjustments will reflect on the next month's invoice and payment. If funds are not available at the time of the withdrawal, the payment will not be made and penalties could apply to the Employer.

I do not wish to set up direct withdrawal at this time. I understand that at any time, I can request automatic withdrawal by completing this form and submitting it to wfbh@rehnonline.com

Signature of Officer

Printed Name

Title

Date