AUTOMATIC HEALTHCARE DEDUCTIONS
for TeamstersCare Retirees
in the New England Teamsters Pension Fund

AUTHORIZATION FORM

If you're a retiree and you're paying premiums for your TeamstersCare retiree health care coverage, you can elect the "automatic deduction" payment option. This means that, *with your written approval,* the Pension Fund will deduct from your monthly pension the amount you would normally contribute, as a separate payment, for your retiree medical benefits.

With automatic deduction, you no longer have to bother with getting your check into the Health & Welfare Fund before the end of each month. *Automatic deduction is strictly for your convenience and is completely optional.* The Pension Fund will not deduct health premiums from your pension check unless you authorize them to do so.

If you elect automatic deduction,
you *must* complete this form and return it to:

Teamsters Union 25 Health Services & Insurance Plan
529 Main Street, Suite 209 Charlestown MA, 02129
(LOCAL) 617-241-9220 • (IN MA) 800-442-9939 • (OUTSIDE MA)800-225-6135
(FAX) 617-241-8168 • www.teamsterscare.com

Your automatic deduction election will not take effect until we have received and processed this form.

Please check the box:

☐ *I **do** elect the automatic deduction option.*

As a participant of the Teamsters Union 25 Health Services & Insurance Plan ("Health Services Plan"), I hereby authorize the New England Teamsters and Trucking Industry Pension Fund ("Pension Fund") to deduct from my monthly pension benefit the premium necessary to pay my cost of coverage under the Health Services Plan and to forward said sum to the Health Services Plan.

I understand that if this Authorization is filed at the office of the Health Services Plan in a timely manner, it shall become effective on the first day of the month following the execution of this Authorization Form. This Authorization shall remain in effect until revoked in writing by me and notice of the revocation is filed with the Health Services Plan.

_____ _____

Participant's Signature | Participant's Printed Name

_____ _____

Participant's Social Security Number | Date

REV. 11/21

Teamsters CARE