



**AUTHORIZATION AGREEMENT FOR  
AUTOMATIC WITHDRAWAL OF HEALTH PLAN  
PREMIUMS BY ELECTRONIC FUND TRANSFER**

Phone (706) 841-7000 • Toll Free (877) 937-9602  
Fax: (706) 841-7020 • www.nifmcp.com

Return the completed form by fax to (706) 841-7020, by email to [fmcp\\_customer\\_service@nifmcp.com](mailto:fmcp_customer_service@nifmcp.com) or by mail to:  
NECA/IBEW Family Medical Care Plan  
410 Chickamauga Avenue, Suite 301  
Rossville, GA 30741

**THIS FORM IS FOR RETIREE USE ONLY.**

I hereby authorize the NECA/IBEW Family Medical Care Plan ("Fund") to initiate debit entries, and to initiate, if necessary, credit entries and adjustments to correct any debit entries made in error to my account, at the financial institution named below:

Name of Financial Institution (Bank): \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PLEASE ATTACH A VOIDED CHECK SO WE CAN VERIFY THE FOLLOWING:**

Account Type:  Checking  Savings

Transit/ABA Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

This authorization is to remain in full force and effect until the Fund receives written notification from me of its termination in such time and in such manner as to afford the Fund and Financial Institution a reasonable opportunity to act.

Printed Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

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

**NOTE:** Changes affecting electronic transfers must be received by the Benefit Office no later than the 15th in order to be effective the 1st of the following month.