

Bank Draft Authorization Form

I authorize my bank to charge my account for the amount of my monthly health insurance premium payable to the Consolidated Associations of Railroad Employees (**CARE**).

Please complete the following Information. Your request cannot be processed if incomplete.

_____ Name of Association Member	_____ SS / ID Number
_____ Name of Bank	_____ Bank Phone #
Routing Number: <u> </u> / <u> </u> / <u> </u> / <u> </u> / <u> </u> / <u> </u> / <u> </u> / <u> </u> / <u> </u> (A voided check must accompany this form)	Account Number: _____
Checking <input type="checkbox"/> Savings <input type="checkbox"/>	Draft Cycle: Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly <input type="checkbox"/>

I wish my account to be drafted beginning with the month of:_____

This authority is to remain in full force and effect until **CARE** and Bank have received written notification from me of its termination in such time and in such manner as to afford **CARE** and Bank reasonable opportunity to act on it.

_____ Signature of Member	_____ Date
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CARE

Consolidated Associations of Railroad Employees

CARE invites you to sign up for Automatic Bank Draft, a special member service that will save you time and money every month. By using the plan, you will save money, postage and checks and you will not have to worry about your payment arriving on time.

Just complete the Bank Draft authorization on the reverse side of this card, attach a voided check and return both to **CARE**. Your Automatic Bank Draft will be set up within 30 days after you return the authorization. Once you are on the plan, your monthly bank statement will reflect the amount paid and the date the amount was deducted from your checking/savings account.

Please contact our office if you should change address, banking facility or wish to discontinue the plan.

Consolidated Associations of Railroad Employees (**CARE**)
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