SCREEN ACTORS GUILD-PRODUCERS PENSION & HEALTH PLANS

Earned Premium Auto Debit Plan Application Form
Checking or Savings Account Debit

☐ New Applicant ☐ Change *(Change in bank or account information)*

Participant's Name :_____
Please Print

SSN#:_____Telephone #:_____Effective Quarter & Year:_____

DEBIT OPTION SELECTED: Checking Account ☐
Please check one only
Savings Account ☐

Note: ***If you are electing a withdrawal from a savings account, please verify the account number with your bank. If you are electing a debit from a checking account, please attach a copy of a voided blank check.***

NAME OF BANK:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

BANK TELEPHONE NUMBER:_____

BANK ACCT.#:_____

ABA (ELECTRONIC ROUTING) #:_____

I,_____ authorize Screen Actors Guild – Producers Pension and Health
Participant, Acct. holder if not participant
Plan to withdraw the scheduled quarterly Health Plan premium payment from my checking or savings account on the 25th of the month prior to the premium due date based on the information provided by me on this form. **I further authorize the Health Plan to adjust this withdrawal to reflect a rate change that may occur due to a change in premium Plan type (e.g. Plan I to Plan II or the reverse)**. This authority is to remain in full force and effect until the Health Plan has received written notification from me of its termination or until the Health Plan has sent me a 10-day written notice of the termination of this agreement or until I lose Earned eligibility.

_____ _____
Participant's Signature required Date

_____ _____
Acct. Holder's Signature required - if not Participant Date

This service applies to U.S. bank accounts only

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