

**TEAMSTERS BENEFIT TRUST – RETIREMENT SECURITY PLAN (RSP SILVER)
AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT
Automated Clearing House (ACH) Debits**

I (we) hereby authorize Teamsters Benefit Trust, hereinafter called "TBT," to initiate Automated Clearing House (ACH) debit entries to my (our) () CHECKING () SAVINGS account (select one) indicated below at the Depository Financial Institution named below, hereinafter called "BANK," and to debit the same to such account.

BANK NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

BANK ROUTING NUMBER _____ BANK ACCOUNT # _____

The amount debited will be equal to the full monthly self-payment amount required to maintain health and welfare benefits under the TBT Retirement Security Plan (RSP Silver). The monthly debit to my (our) bank account will be scheduled to take place regularly on the same day of each month (select ONE of the following):

*The first day of each month, effective _____ * The 10th of each month, effective _____

* I (we) understand that Retirement Security Plan (RSP Silver) self-payments are due the first day of each coverage month and all self-payments must be received at the TBT Plan Administration Office before coverage is applicable for each month.

I (we) understand that if there are insufficient funds on the day I (we) have selected for the monthly bank debit to take place, it is my (our) responsibility to make timely payment by check for that month.

I (we) understand that if self-payments are not received by the TBT Plan Administration Office by the last day of the coverage month, coverage for me and my covered spouse permanently ends (effective the first day of that same month).

I (we) understand that RSP Silver self-pay rate increases are effective October 1st each year and authorize TBT to change the debit amount to equal the new rate for the coverage selected for the term of this Authorization Agreement.

This Authorization Agreement is to remain in full force and effect until TBT has received 30 days written notification from me (or my covered spouse) of its termination.

NAME _____ TBT ID NUMBER _____
(Please Print)

DATE _____ SIGNATURE _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

SEND SIGNED FORM AND A COPY OF YOUR VOIDED CHECK TO TBT AS FOLLOWS:
FAX to (510) 795-9237 OR EMAIL to Retiree COBRA@lipmantpa.com
OR MAIL to the TBT Plan Administration Office, 39420 Liberty Street, Suite 260, Fremont, CA 94538-2200

NOTE: ALL REQUESTS FOR CHANGES TO THE DEBIT SCHEDULE OR TERMINATION OF THIS DEBIT AUTHORIZATION MUST BE PROVIDED IN WRITING 30 DAYS PRIOR TO THE DATE OF THE CHANGE.