MULTLNOMAH BAR ASSOCIATION
Group Health Insurance Plan and Trust

Automatic Bank Withdrawal Form

Authorization Agreement For Direct Payments (ACH Debits)

Employer/Individual Name: _____ Employer ID Number: _____

I (we) hereby authorize **Aldrich Benefits LP / MBA Group Insurance Plan and Trust** hereinafter called **COMPANY**, to initiate debit entries to my (our) ___ Checking Account / ___ Savings Account (select one) indicated below at the depository financial institution named below, hereinafter call **DEPOSITORY**, and to debit the same so such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depository Name: _____ Branch: _____

City: _____ State: _____

Routing Number: _____ Account Number: _____

The Payment will be deducted from your account on the 1st of the month for the month of coverage. (e.g., 1st of April to pay for April coverage)

This authorization is to remain in full force and effect until **COMPANY** has received written notification from me (or either of us) of it's termination in such time and in such manner as to afford **COMPANY** and **DEPOSITORY** a reasonable opportunity to act on it.

Name(s): _____ Employer ID Number: _____

Date: _____ Signature: _____

NOTE: ALL WRITTEN DEBIT AUTHORIZATION *MUST* PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.

Send this completed form to:

Aldrich Benefits LP
P.O. Box 5253
Portland, Oregon 97208
Fax: 503-589-9399
Email: scarpentier@aldrichadvisors.com