AUTHORIZATION FOR CREDIT CARD PAYMENTS

IATSE National Health and Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204
(Tel) 212-580-9092/ 1-800-456-3863 (Fax) 646-783-7650 (email) psc@iatsenbf.org

IMPORTANT: This form must be completed by you, the participant, and submitted to the Fund Office if you wish to authorize Fund Office staff to make a manual credit payment on your behalf for your coverage. You must fill in your name, participant ID number, sign and date the form, and send it to the Fund Office by mail, fax or email.

After this Form is received and processed by the Fund Office, you can contact participant services at 1-800-456-3863 or via e-mail at psc@iatsenbf.org to process a credit card payment (MasterCard or Visa only) on your behalf.

1._____, _____, hereby authorize the Fund to accept
Print Name Participant ID #
credit card payments from me for my health plan coverage as indicated on my statement or COBRA invoice.

Participant Acknowledgement (to be signed by Participant)

By signing this Authorization Form, I acknowledge, agree and understand that:

1. **Once this Form is received and processed by the Fund Office, I will be able to contact the Fund Office to make manual credit card payments for my health coverage. My completion of this Form itself does not constitute payment. In order to authorize payment, I must contact the Fund Office.**

2. **This Authorization will remain in effect until I revoke it in writing to the Fund Office.**

3. **If the full amount due is not timely paid, my health coverage will either be downgraded to a lower cost option or will lapse, in accordance with the rules described in the Plan's Summary Plan Description Booklet.**

4. **I may pay for coverage with an authorized credit card *issued in MY name.* However, if a credit card issued in another person's name has been used to pay for my coverage, and the payment is not valid for any reason, I understand I may be treated as if no payment was made and may be defaulted into coverage or lapsed from coverage based on Plan rules. If coverage is provided, I understand that I remain responsible for the full amount of such payment, or if greater, the value of the coverage of benefits provided in reliance on such payment.**

5. **If the applicable credit card payment is not honored by the credit card issuer for any reason including but not limited to, because I have exceeded my credit limit or I disputed the payment, my coverage may be downgraded or lapsed in accordance with rules described in the Plan's Summary Plan Description Booklet. I can avoid a discontinuance of coverage by submitting a timely payment to the Fund of the full amount due by some other means by the required deadline date to continue my health coverage**

6. **I understand that I may only make changes to my current enrollment selection if I have a change in family status or other special enrollment right in accordance with the terms of the Plan and in the manner specified by the Fund Office. If I experience such a change or enrollment right, I must contact the Fund Office within 30 days of the event. If I have a change in family status after I have made a payment by credit card or check, and such change causes my coverage to change to an option that costs less, it is the Fund's policy to issue a refund by check for the appropriate amount. The Fund will NOT issue a credit toward future coverage.**

7. **The Fund (including its Trustees, administrators, employees and agents) is not responsible for any actions or omissions that the applicable credit card company may commit or allow to occur in violation of that company's legal, contractual or other obligations to me. The Fund is also not responsible for any costs or expenses that I may incur (or any other consequence) arising out of: (a) the credit card company's failure to make payment to the Fund in accordance with my on-line payment instructions for any reason, or (b) my failure to timely make a credit card payment via the Fund's website.**

_____ _____
Participant's Signature **Date**