SAG·AFTRA HEALTH PLAN | SAG·Producers PENSION PLAN

3601 W. Olive Ave., Burbank, CA 91505
Mailing Address: P.O. Box 7830, Burbank, CA 91510-7830
P (800) 777-4013 • F (818) 953-9880
www.sagaftraplans.org

Dear Employer,

We are in the process of transitioning employer payments to electronic payments.

In order to set up an electronic payment, we will need you to complete and sign the enclosed enrollment form. Please provide proof of your bank account as indicated on the enrollment form (e.g., a voided check, bank statement, or a letter from your bank.)

Send the signed and completed form along with bank account verification information and a current W-9 to:

Mail: Accounting department
SAG-AFTRA Health Plans
P.O. Box 7898
Burbank, CA 91510-7898
Or
Email: AP@sagaftraplans.org

If you have any questions, please email us at the address above. Thank you in advance for your cooperation.

Sincerely,

SAG-AFTRA Health Plan and SAG-Producers Pension Plan

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Electronic Payment Enrollment Form

Employer Information

Payee Name:

Taxpayer ID Number:

Mailing Address:

Contact Name / Dept:

Contact Phone Number:

Contact E-Mail Address:

Remittance E-Mail Address:

Financial Institution Information

Proof of account required: Enclose a voided check, bank statement copy or bank letter confirming the name of account owner and account number.

Name on Account:

Financial Institution Name: Phone:

Financial Institution Account Number: ☐ Checking ☐ Savings

Routing / Transit Number:

Financial Institution Address:

Transaction Information

☐ **Initial Authorization**

I/we hereby authorize the SAG-AFTRA Health Plan and/or the SAG-Producers Pension Plan (SAG-AFTRA Plans) to electronically deposit in the account listed above and, if necessary, correct any such deposits by making adjustments to my account at the financial institution I/we have indicated on this form. This authorization will remain in force until SAG-AFTRA Plans has received written notification from the payee of any changes or termination.

☐ **Change Request**

I/we hereby request a change of the authorization on file to the account information listed above. This authorization will remain in force until SAG-AFTRA Plans has received written notification from the payee of any changes or termination.

☐ **Termination**

I/we hereby terminate the authorization for electronic payments for the above payee.

Authorization

Authorized company representative - signature | Authorized company representative - printed | Title | Date