Research Foundation for Mental Hygiene, Inc.
Retiree Health Insurance Auto Withdrawal Enrollment Form

Make your check or money order payable to:
Research Foundation for Mental Hygiene, Inc.
Attn: Starr Ross
150 Broadway, Suite 301
Menands, New York 12204

**Include the last four digits of your Social Security Number on your payment*

Payments are due on the first of each month for the following month of coverage. Payments not made timely will result in the cancellation of coverage for you and or your dependent(s).

Employee Name:
Employee address:

Note:
Employee Social Security Number: XXX – XX –

Amount Due: $

Amount Enclosed: $ _____

Benefit Program:
Plan Name: Empire Blue Cross
Coverage:

The next payment that will be due: _____
_____

☐ By selecting this option and signing below I am authorizing RFMH to automatically withdraw $ _____ from the account indicated below between the 25th and 30th of each month to pay my retiree health insurance. If adequate funds are not available at the time the withdrawal is made then your coverage may be cancelled for you and your dependent(s) as your payment will be considered late.

Bank Routing Number: __ __ __ __ __ __ __ __ __ __ __ __

Account Number: __ __ __ __ __ __ __ __ __ __ __ __

Bank Name _____

☐ Checking Account ☐ Savings Account

_____ Date: __ / __ / ____
Employee Signature

Should you have any questions regarding your coverage and or payment information you may contact Starr Ross at (518) 486-4218 or by e-mail at: *sross@rfmh.org.*