MAILING ADDRESS: P.O. BOX 47 ■ WAUKESHA, WI 53187-0047
STREET ADDRESS: W234 N2000 RIDGEVIEW PARKWAY COURT ■ WAUKESHA, WI 53188-1022
PHONE: 262-506-6700 ■ TOLL FREE: 866-899-3204 ■ FAX: 262-506-6124 ■ www.atcllc.com

# Authorization for Automatic Debits for Payment of Retiree Medical and/or Dental Premiums:

Please complete the following form to authorize automatic debits from your bank account for payment of Retiree Medical and/or Dental Premiums. Please return the completed forms along with a voided check to ATC Treasury Department at the following address:

**American Transmission Company LLC**
**Treasury Department**
**P.O. Box 1421**
**Waukesha, WI 53187-1421**
**Fax: 262-506-6711**

For questions when filling out this form, please contact Human Resources at 262-506-6872.

By execution of this authorization, the applicant hereby authorizes ATC to initiate Automated Clearing House (ACH) debits to the bank account at the applicants' financial institution listed below. This authority will be for the sole purpose of collecting funds to pay Retiree Medical and/or Dental Premiums.

This authorization will remain in effect until cancelled in writing by one of the authorized representatives identified below. Written notification of cancellation will be effective if received at least three business days (3) days prior to the next scheduled payment due date. The applicant may change authorized parties at its discretion by giving ATC written notice of such change in authorized parties delivered to the address set forth above.

Failure by ATC to initiate the automatic debit in a timely manner will not result in a late payment. If ATC initiates the automatic debit in a timely manner and the automatic debit is rejected due to insufficient funds or some other action of the applicant, the payment will be considered late.

If the applicant has an ACH filter on the account listed below, the applicant must add Company ID #1391999364 to the filter in order for ATC to execute the ACH debit.

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# Authorization for Automatic Debits for Payment of Retiree Medical and/or Dental Premiums:

### *Applicant Identification and information*

| | |
|---|---|
| **Name:** | |
| **Address:** | |
| **City, State, Zip Code:** | |
| **Email Address:** | |

### *Financial Institution Information*

| | |
|---|---|
| **Financial Institution Name:** | |
| **Street Address of Financial Institution:** | |
| **City, State, Zip Code:** | |
| **Account Name:** | |
| **Account Number:** | |
| **ABA Routing Number:** | |

### *Account Holder/Owner Signature Required For All New and Updated Submissions*

| | |
|---|---|
| **Account Holder/Owner Name:** | |
| **Date:** | |
| **Signature:** | |

Please return completed form to ATC Treasury Department:

**American Transmission Company LLC**
**Treasury Department**
**P.O. Box 1421**
**Waukesha, WI 53187-1421**
**Fax: 262-506-6711**