

Baldwinsville Central School District

Automatic Payment Plan (AutoPay) Authorization Form

Action [] New Application – first time enrollment [] Change Request – to update banking information

Retiree Subscriber Name: _____

Information Home Address: _____

Please Print Daytime Phone: _____ Email: _____

Authorization I authorize Baldwinsville Central School District to initiate automatic deductions from my account with the financial institution named below for the monthly payment of my retiree medical and/or dental insurance premium(s), including transactions that may be necessary to correct any changes. This authority shall remain in effect until such time that the insurance coverage is discontinued by either party. I understand that I will receive written notification of the monthly premium amount due for my insurance coverage annually, in September, and anytime a change may occur during the year. I have read and agree to the provided Terms and Conditions documentation.

Financial Name: _____ Phone: _____

Institution Address: _____

Account Holder Name: _____

I elect to withdraw from my: [] CHECKING Account [] SAVINGS Account

I confirm that I have authority to make withdrawals from this account. I understand that the automatic deductions are ACH transactions and they must comply with the provisions of U.S. law and originate from a U.S. financial institution.

Complete either Section A or Section B, but not both.

Section A:

Checking Account Transactions

In order to withdraw from a checking account, you MUST attach a voided check to this form.

ABA Transit / Routing Number input field (9 boxes)

Account Number input field

ABA Transit / Routing Number

Account Number

Section B:

Savings Account Transactions

To withdraw from a savings account, you MUST obtain a signature from a Bank Representative certifying that the savings account information provided is accurate for ACH transactions.

ABA Transit / Routing Number input field (9 boxes)

Account Number input field

ABA Transit / Routing Number

Account Number

Bank Representative: _____ Date: _____

Please SIGN: Retiree Signature: _____ Date: _____

Mail to: Baldwinsville Central School District, Attn: Benefits, 29 E. Oneida St. Baldwinsville, NY 13027