Baldwinsville Central School District

Automatic Payment Plan (AutoPay) Authorization Form

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

Retiree Information *Please Print*

Subscriber Name: ____

Home Address: ____

City: ____ State: _________ Zip: ____________

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 August, and anytime a change may occur during the year. I have read and agree to the provided Terms and Conditions documentation.

Financial Institution

Name: ____ Phone: _____________________

Address: ____

Account Holder Name(s): ____

I elect to withdraw from my: ☐ **CHECKING** Account ☐ **SAVINGS** Account

ABA Transit / Routing Number

Account Number

Checking Account authorizations require the attachment of a voided check to this form. If authorizing for a **Savings Account** transaction, you should confirm with your bank that the savings account information provided is accurate for ACH transactions.

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.

Please SIGN: Retiree Signature: ____ Date: ________________

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

RETURN FORM BY ________________