PARKWAY SCHOOL DISTRICT
AUTHORIZATION FORM
DIRECT DEBIT OF ACCOUNT
HEALTH INSURANCE PAYMENTS

Name:_____ SSN# __XXX-XX-_____
Last First

Phone #_____ E-Mail Address: _____

Check Applicable Election:

_____New participant. Complete and sign this form. Attach a voided check.

_____Change of accounts and/or financial institution. Complete and sign this form. Attach a voided check for new checking account or deposit slip for new savings account.

_____Cancel participation. Sign form.

Select Primary Account:

Checking Account #_____OR Savings Account # _____

Bank Routing # _____ (9 numbers)

Dollar amount to be debited per month: $_____

Payment Period (Select one): 1st of Every Month_____ OR 15th of every Month_____

Financial Institution Name_____

City and State _____

AUTHORIZATION STATEMENT:

I hereby authorize Parkway School District and the financial institution above to debit my Account electronically each payment period. This authority will remain in effect until I have signed a new Authorization, or upon cancellation of participation.

I agree I will provide Parkway School District thirty (30) days advance notice prior to changing financial institutions.

At the bottom of this form, attach a VOIDED CHECK for the account to be used for your deduction. If you want to use two accounts to pay for your premium, please attach a check for each account, and the amount you want taken out of each account. **TO CANCEL YOUR DEDUCTION, THE BENEFITS DEPARTMENT MUST BE NOTIFIED IN WRITING 15 DAYS PRIOR TO THE NEXT DEDUCTION DATE!**

Signature: _____ Date:_____

Return this form to: Parkway School District
Attn: Benefits
455 N. Woods Mill Rd.
Chesterfield, MO 63017

Attach Voided Check Here