Finance Department
455 N. Woods Mill Road
Chesterfield, MO 63017
(314) 415-8059

ACH AUTHORIZATION FORM

DIRECT DEBIT FOR HEALTH INSURANCE PREMIUMS

Participant Information:

Full Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Mailing Address: _____

Action (check one):

- ☐ New Authorization (enroll in automatic debits)
- ☐ Change Bank Account
- ☐ Cancel Authorization (stop automatic debits)

Bank Account Type (check one):

- ☐ Checking ☐ Savings

Payment Options:

- ☐ MONTHLY on the 1st
- ☐ MONTHLY on the 15th
- ☐ ANNUAL on the 1st – You may pay off your entire remaining balance for the 12-month period. This payment will be processed on the 1st of the month after we receive this form.

Bank Account Details:

Bank Name: _____

Routing #: _____(9 digits) Account #: _____

Authorization Statement

I authorize Parkway School District ("Parkway") to electronically debit (and if necessary, credit) the bank account listed above for payment of my health insurance premiums.

Recurring Debits: Parkway will debit my account each month on the selected date (1st or 15th) and in the amount of my health insurance premiums currently due. This authorization remains in effect until I submit a cancellation or new authorization.

Failed Payment Reattempts: If a payment is returned due to insufficient funds or similar reasons, I authorize Parkway to reattempt the debit up to two (2) additional times. If I have revoked or stopped the debit, Parkway will not reattempt without my consent.

Return Fee: If a payment is returned, I authorize Parkway to charge a $10 return fee to my account per failed transaction. I understand this fee amount may change in the future based on applicable law or district policy, and I will be notified of any change.

Premium Changes & Adjustments: I understand that my premiums may change due to rate increases, coverage changes, or updates I make to my benefits (such as adding/dropping dependents). Parkway will give at least 10 days' notice for district-initiated premium changes. For other changes (including dependent age-outs or changes made through your benefits portal or other means), I understand that the updated premium will be shown on my coverage summary, and no separate notice will be provided by Parkway. I also authorize Parkway to make additional one-time debits or credits as needed to correct billing errors, collect unpaid balances, or issue refunds. Parkway will notify me via email (or mail if no email is available) before processing any one-time adjustment.

Cancellation: I may cancel this authorization at any time by notifying Parkway in writing at least 5 business days before my next scheduled payment. I understand that cancellation of this authorization will stop future debits and credits but does not cancel my benefits coverage or premium obligation.

IMPORTANT – Consequences of Non-Payment: Failure to pay required premiums (including due to insufficient funds, revoked ACH authorization, or cancellation) may result in termination of health insurance coverage. Coverage will be permanently terminated for any account that is more than 60 days past due. Parkway will provide notice before coverage is terminated due to non-payment.

By signing below, I represent that I am the owner or authorized signer on the bank account listed above. I acknowledge that I have read and agree to the terms of this ACH authorization. I understand the rights and obligations described above, and I authorize Parkway School District to debit (and if necessary, credit) my bank account accordingly.

Signature: _____ **Date:** _____

Submission Options Mail: Parkway School District, Attn: Benefits
455 N Woods Mill Rd, Chesterfield, MO 63017
Fax: (314) 415-8050

– Due to the sensitive information included on this form, we do not recommend returning it via email. –