PUYALLUP SCHOOL DISTRICT

A Tradition of Excellence

Clear Print

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS
(ACH WITHDRAWALS)
Puyallup School District
Self Pay premiums

Employee Name:_____

Employee #: _____

I (we) hereby authorize the Puyallup School District to initiate debit entries from my (our) checking account indicated below. This deduction will occur on the 5th of each month or the next business day for that month's medical, vision and/or dental coverage. I (we) acknowledge that the origination of ACH transaction to my (our) account must comply with the provisions of U.S. law.

In addition, a $25 NSF fee will be collected for returned checks if applicable.

Required information:

Financial Institution & Routing #: _____

Account Number: _____

☑ Bill all charges to the above bank account per my billing arrangement with Puyallup School District Benefits office. If there is a change in the payment amount, I will receive notification from the Benefits office prior to the next scheduled transaction date.

☑ This authorization is valid until I provide you with written cancellation.

Insufficient funds within the account or failure to pay in a timely manner will result in cancellation of your coverage and/or referral to a collection agency.

_____ _____

Signature Today's Date

Please return completed form to: **Puyallup School District, PO Box 370, Attention Benefits Office, Puyallup, WA 98371**
If you have any questions, please call 253.841.8615

Please attached a VOIDED CHECK here.