RETIREE INSURANCE COVERAGE & DRAFT FORM

❑ New ❑ Change

Name: _____

Address: _____

Amount

Health Coverage: ❑ Self Only ❑ Self/Spouse _____
❑ Self/Family ❑ Declined

Dental Coverage: ❑ Self Only ❑ Self/Spouse _____
❑ Self/Family ❑ Declined

First payment due: -10-
*First payment is due on the 10th of the month during which the employee retirees.

First draft due: -15-
*Must complete bottom portion of form and attach voided check.

Cancel draft on: _____

I understand that failure to pay insurance premiums by the 15th of each month, for the next month's coverage, will result in cancellation of coverage.

_____
Signature Date

RETIREE AUTOMATIC PAYMENT AUTHORIZATION

ATTACH A VOIDED CHECK TO THIS FORM (Deposit slips & Bank Cards are not accepted)

I authorize you and the financial institution listed below to initiate electronic credit entries, and if necessary debit entries and adjustments for any credit entries in error to my:

❑ Checking Account ❑ Savings Account SSN _____

each payday. This authority will remain in effect until I have cancelled in writing.

_____ _____
FINANCIAL INSTITUTION NAME (PLEASE PRINT)

_____ _____
CITY ACCOUNT NUMBER

_____ _____
DATE SIGNATURE

*NOTE: DIRECT DEPOSIT TAKES 2 PAY PERIODS TO TAKE EFFECT.

FOR PAYROLL USE ONLY:

ROUTING NUMBER

:									

ACCOUNT NUMBER

:											

Prenote: _____ **Effective date:** _____