SPOTSYLVANIA COUNTY SCHOOLS

AUTHORIZATION AGREEMENT FOR DIRECT DEBIT

I hereby authorize the Spotsylvania County School Board to initiate debit entries to my checking/savings account for the payment of my monthly health insurance premium and to make any necessary credit entries to my account. I understand that the full amount of my monthly premium will be deducted from my account on the 25th of each month and that I will be charged a $25.00 service fee if the total amount due cannot be withdrawn from my account on the draft date. Failure to maintain an adequate balance in my checking/savings account to cover my health insurance premium will be considered a non-payment of premium and coverage will be terminated. Otherwise, this authority is to remain in full force and effect until the payroll office receives written notification of its termination. Notification must be mailed to the Finance Office, Attention: Marcia Stevens, 8020 River Stone Drive, Fredericksburg, VA, 22407, no later than three weeks before the draft date.

Signature: _____

Date: _____

New Request ☐

Change Request ☐ Effective Date of Change_____

Name (please print): _____

Address: _____

City, State, ZIP: _____

Daytime Phone #: _____

E-mail address (optional):_____

Name of Bank or Credit Union: _____

Type of account:

_____ Checking account **(Enclose an original or copy of a voided check with this form)**

_____ Savings account **(Enclose an original or copy of deposit slip with this form)**

For Payroll Use Only

TRANSIT ROUTING NUMBER **CHECKING/SAVINGS ACCOUNT NUMBER**

_____ _____