



THOSE RECEIVING A MONTHLY RETIREMENT CHECK FROM SERS ARE NOT ELIGIBLE
Authorization Agreement for Direct Payment of Monthly Health Care Premium

Name: _____

Personnel Number: _____

Phone Number: _____

Email Address: _____

Bank Name: _____

Bank Street Address: _____

Bank City, State, ZIP Code: _____

Bank Information (see reverse for example):

Routing Number: _____ Account Number: _____

Please **enclose a voided check** and indicate whether this is a savings or checking account:

_____ Savings _____ Checking

I authorize the Pennsylvania State System of Higher Education (PASSHE) to initiate monthly debit entries to my bank account at the banking institution named above for my health care premiums. **I understand that my health care coverage may be canceled if PASSHE cannot deduct the monthly payment due to insufficient funds or the account being closed.** I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until PASSHE has received written notification from me of its termination in such manner as to afford PASSHE and my banking institution a reasonable opportunity to act upon it.

Signature: _____ Date: _____

Please contact 717-720-4153 or RetireeBenefitHelp@passhe.edu with any questions. Fax or mail the completed authorization form and a **voided check** to:

Fax: 717-720-4013

U.S. Mail: Pennsylvania's State System of Higher Education
Office of the Chancellor
Attention: AHCP Benefits
2986 North Second Street
Harrisburg, PA 17110

Sample voided check showing (1) Routing Number, and (2) Bank Account Number.

ABC BUSINESS
1234 Park Avenue
Anytown, CA

1044

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PAY TO THE ORDER OF _____ \$

_____ DOLLARS

Anywhere Bank
U.S.A.
MEMO _____

Not Negotiable

⑆133404567⑆1234561304⑆⑆⑆*1044

3 - Check Number

2 - Bank Account Number
(not to exceed 17 digits)

1 - Routing Number (Requies 9 Digits)