SPRINGFIELD PUBLIC SCHOOL DISTRICT

AUTOMATIC BANK DRAFT –

WILL BE DEDUCTED ON 10TH OF MONTH (Or next business day if a holiday)

PRE-AUTHORIZED AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

I (we) hereby authorize Med-Pay, to debit entries to my (our) account indicated below and the Financial Institution named below, hereinafter called FINANCIAL INSTITUTION, to debit same to such account. I (we) acknowledge the origination of ACH transactions to my (our) account must comply with the provision of U.S. law.

I (we) realize that the transfer will occur on a regularly scheduled date. I (we) also understand that as premiums fluctuate, I (we) will be notified prior to the charge to my (our) account.

This authorization is to remain in full force until Med-Pay, Inc. has received written notification from me of its termination in sufficient time and manner as to afford Med-Pay, Inc. and my FINANCIAL INSTITUTION a reasonable opportunity to take action to terminate this agreement.

(PLEASE PRINT)

NAME	Alt ID # or SOCIAL SECURITY NUMBER

NAME OF FINANCIAL INSTITUTION	TYPE OF ACCOUNT
	□ CHECKING □ SAVINGS □ OTHER

ROUTING NUMBER	ACCOUNT NUMBER

or attach a voided check

ATTACH VOIDED CHECK HERE

_____ _____

Authorization Signature **Date**

_____

Contact phone number