Print Form

AGREEMENT FOR PREAUTHORIZED BENEFIT PREMIUM PAYMENTS BP

Payroll Office - The University of Michigan

To have your benefit premiums automatically withdrawn from your checking or savings account, complete the following information. If withdrawals will be made from your checking account, please **ATTACH A BLANK, VOIDED CHECK/DRAFT** to this form and return it to:

Payroll Office
G395 Wolverine Tower-Low Rise
3003 South State Street
Ann Arbor, MI 48109-1279

You can also FAX the information to (734) 647-3983. If you have any questions, please contact the HR/Payroll Service Center at (734)-615-2000 or toll free at (866)-647-7657.

Please note that it will be necessary to verify your account information. Therefore, if you are submitting this form after the 10th of the month, you are responsible for the current and next month's premium as well as any previous balance. See Section IV (1) for withdrawal schedule.

SECTION I PERSONAL INFORMATION

Retiree/Surviving Spouse: _____
Last First Middle

University of Michigan ID # (UMID): _____ Daytime Phone: ( ) _____

SECTION II

☐ New Authorization ☐ Change Financial Institution/Change Account ☐ Cancel

Type of Insurance: (Check all that apply) ☐ Medical ☐ Dental Opt 2 ☐ Dental Opt 3 ☐ Vision ☐ Legal

SECTION III ACCOUNT DATA

Financial Institution Name: _____
Account Number: _____

Type of Account: (Check One) ☐ Checking/Share Draft **YOU MUST ATTACH A BLANK, VOIDED CHECK/DRAFT.**
OR
☐ Savings Routing # for Savings Account _____
(Obtain From Your Financial Institution)

SECTION IV

I authorize the withdrawal of my benefit premiums on a monthly basis from the account indicated in Section III. I further agree to the following conditions:

1. The Payroll Office will withdraw the benefit premiums from the account indicated in Section III on the 20th of each month. If the 20th is not a banking business day, the withdrawal will be made on the banking business day that is immediately following the 20th of the month. **This withdrawl will pay the premium for the following month.**
2. This agreement is to remain in force until canceled by me via letter or a revised "Agreement For Preauthorized Benefit Premium Payments" Form sent to the Payroll Office. I realize that I cannot cancel this agreement by contacting my financial institution. Upon cancellation of this agreement, I will begin to make benefit premium payments by check if I wish to continue benefit coverage.
3. Any change to or cancellation of this agreement must be received by the Payroll Office by the 10th of the month for it to take effect in that calendar month.
4. I release the University and its employees from any liability to pay charges for insufficient fund transactions that result from my account balance being less than the benefit premium withdrawal. If I do not have sufficient funds in my account, I realize that my coverage will be canceled.

Signature _____ Date _____