Print Form

AGREEMENT FOR PREAUTHORIZED BENEFIT PREMIUM PAYMENTS BP

Payroll Office - The University of Michigan

To have all of your benefit premiums (i.e. medical, dental opt 2, dental opt 3, vision, legal, life) automatically withdrawn from your checking or savings account, complete the following information.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, 1000 Victors Way, Ann Arbor, MI 48108

You can also FAX this information to (734) 647-3983. If you have any questions about this form, please contact the Payroll Customer Service Area at (734) 615-2000, option 2, prompt 1 or toll free at (866) 647-7657.

Please note, 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 (2) for withdrawal schedule. For questions about your balance, please contact the SSC Benefits Transaction Team at (734) 615-2000, option 1, prompt 1 or toll free at (866) 647-7657.

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

☐ I authorize The University of Michigan to take a deduction to bring my account current. For inquiries about your balance, please contact the SSC Benefits Transaction Team at (734) 615-2000, option 1, prompt 1 or toll free at (866) 647-7657.

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. 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**, which will impact the premium for the following month.
2. 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.**
3. 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.
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 _____