Authorization Agreement for Retiree Medical Premium ACH Debits

Name on Bank Account_____

ID Number (Soc. Sec. #) _____

Retiree Blue Cross Blue Shield Monthly Premium Payment

Medical Premium _____

I (we) hereby authorize Montgomery County Government, herein after called COMPANY, to initiate debit entries and/or correction entries to our ☐ Checking ☐ Savings account (select one) indicated below at the depository named below, herein called DEPOSITORY, to debit the same such account.

If you would like this debit to be taken from your checking account, please attach a blank voided check, if you would like this debit to be taken from a savings account please complete this section:

Depository Name _____ Branch _____

City _____ State _____

Bank Transit/ABA # _____ Account # _____

This authorization is to remain in full force until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY reasonable opportunity to act upon it.

Name _____

Signature _____ Date _____