Authorization for Direct Payment for the UUA Insurance Plans Premium Contribution

Please print in blue or black ink.

Part 1- GROUP INFORMATION			
Company or Group Name			
Authorized Representative		Customer Number	
Street Address	City	State	Zip
Telephone Number	Email Address (optional)		

Part 2 - BANK INFORMATION	
Name of Bank or Financial Institution	
Name as it appears on checking account	
Account from which you would like your payment to be automatically deducted: (check one)	
☐ **Checking Account** **Please enclose a voided blank check with this authorization**	☐ **Statement Savings Account** **** Please enclose a letter from your banking institution verifying your Savings Account Institution, Routing and Account number**

Part 3- AUTHORIZATION FOR DIRECT PAYMENT OF CONTRIBUTION

I hereby authorize the UUA Insurance Plans Billing Office to initiate an ACH Debit to my account for the contribution required for my health care benefits and authorize the financial institution to charge such withdrawals to my account. This amount may be adjusted to correct any overpayments or underpayments, or to reflect any charges by the financial institution due to insufficient funds in my account. I may discontinue enrollment in this direct payment option at any time by notifying the Billing Office in writing.

Signature _____ Date _____

To begin the automatic debit payment, please forward a copy of this completed form and a voided check to:

UUA Billing Office
60 Boulevard of the Allies, Fifth Floor
Pittsburgh, PA 15222

Please keep a copy of this authorization for your records. If you wish to terminate this direct payment option please notify the Billing Office at the above address.