SCOTT COUNTY EMPLOYEE RELATIONS

GOVERNMENT CENTER EAST • 200 FOURTH AVENUE WEST • SHAKOPEE, MN 55379-1220
(952) 496-8103 • Fax: (952) 496-8446 • www.scottcountymn.gov

1. Complete the "Account Information" and "Signature" sections of this form below.
2. Attach a voided check or savings account ticket to this form.
3. Enclose in an envelope and mail to the above address or email to erbenefits@co.scott.mn.us

Direct Payment of Insurance Premiums Authorization Agreement

I hereby authorize **Scott County** to initiate automatic withdrawals from my account at the financial institution named below. I also authorize **Scott County** to make deposits from this account in the event that a debit entry is made in error.

Further, I agree not to hold **Scott County** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in withdrawing funds from my account. Please note that there is a $30.00 fee charged if there are insufficient funds to cover the premium amount.

This agreement will remain in effect until Scott County receives a written notice of cancellation from me or my financial institution, payment of my account is made in full with Scott County, or until I submit a new withdrawal form to Scott County Employee Relations. It is my responsibility to inform Scott County of any changes to my banking information.

Account Information

Participant Name: _____

Participant Telephone Number & Email Address: _____

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ **Checking** ☐ **Savings** ☐

Health Premium: $ _____

Dental Premium: $ _____

Life Insurance Premium: $ _____

Vision Premium: $ _____

Monthly Amount to be withdrawn $ _____. Payments will be withdrawn on the 1st of each month, or the following business day if the 1st is on a holiday or weekend.

Signature

Authorized Signature: _____ **Date:** _____