Pennsylvania's STATE SYSTEM of Higher Education

Authorization Agreement for Direct Payment of Monthly Health Care Premium

(Valid when no monthly SERS annuity payment will be received by a State System annuitant/surviving spouse.)

Name: _____

Personnel Number: _____

Phone Number: _____

Personal Email Address: _____

Bank Name: _____

Bank Street Address: _____

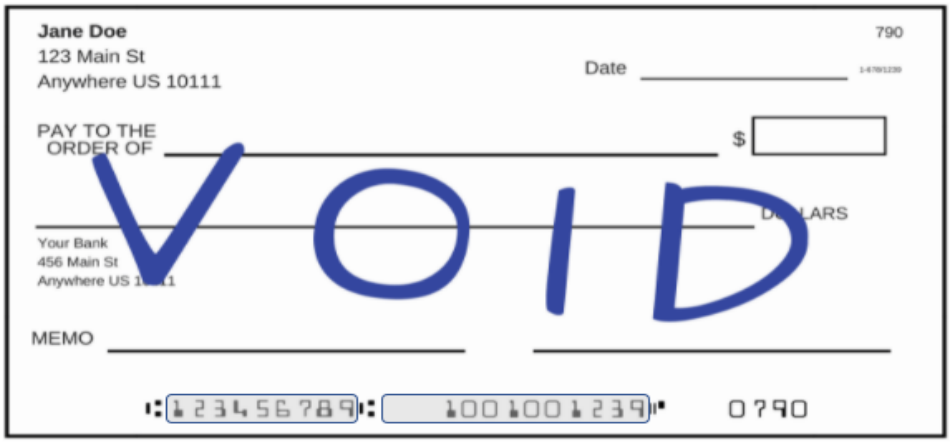
Bank City, State, ZIP Code: _____

Routing Number**: _____

Account Number**: _____

Account Type**: ☐ Savings ☐ Checking

****Voided check required with completed form**



Sample voided check to assist with completing form.

If savings account will be used , please provide a voided deposit slip, account statement, or letter from your bank that confirms the routing and account numbers listed on the form.

Routing Number (9 digits) | Account Number (cannot exceed 17 digits)

I authorize the Pennsylvania State System of Higher Education (PASSHE) to initiate monthly debit entries to my bank account at the banking institution named above for my health care premiums. **I understand that my health care coverage may be canceled if PASSHE cannot deduct the monthly payment due to insufficient funds or the account being closed.** I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until PASSHE has received written notification from me of its termination in such manner as to afford PASSHE and my banking institution a reasonable opportunity to act upon it.

Signature: _____ Date: _____

Form and voided check may be faxed, emailed, or mailed to the Annuitant Health Care Program Office.

Fax: 717-720-4162 | Email: retireebenefithelp@passhe.edu | Mail: PA State System of Higher Education
System Office- AHCP Benefits
2300 Vartan Way, Suite 207
Harrisburg, PA 17110