FOOTHILL-DE ANZA
Community College District

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

Authorization for Automated Deposit and/or Withdrawal for the Following Transactions: (1) Monthly Payment of Retiree Health Plan Contributions; 2) Quarterly Survivor Health Plan Payments; (3) Monthly Reimbursement of Retiree Health Plan Contribution Overpayments; and (4) Quarterly Reimbursement of Medicare Part B Premiums.

Employer Name: **Foothill-De Anza Community College District**

Participant Information

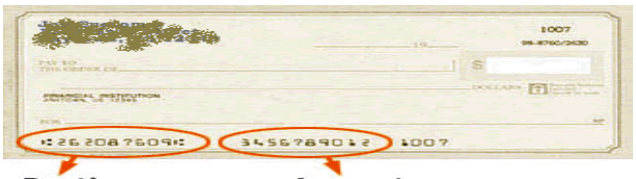
Name (Last, First)	Social Security Number
Address	City/State/Zip
Email Address	Phone Number

☐ **I hereby authorize Secova on behalf of FHDA to electronically withdraw the amount of my monthly or quarterly benefit plan contributions (including any associated bank charges) from the designated checking or savings account listed below**

☐ **I hereby authorize Secova on behalf of FHDA to electronically deposit the amount of my monthly or quarterly reimbursements for Medicare Part B premiums or overpayment of my benefit plan contributions to the designated checking or savings account listed below**

Note: This form may take up to 10 business days from the date received to process. If I am mailing this form close to the 1st of the month for which the premium payment is due, I will include a check for my first payment due on the 1st. Automatic withdrawals will then commence on the following premium payment due date.

Name of Financial Institution			
Mailing Address	City	State	Zip Code



Routing Number:
Account Number:
Type of Account ☐ Checking ☐ Savings
Requested Effective Date:

I understand and agree that: (1) automatic withdrawals will continue until I either cancel this agreement by submitting the request in writing to the address below, or cancel my district paid benefits; (2) withdrawals will be made on the 1st of the month for which the payment is due (or on the next banking day if the 1st is a non-banking day); (3) submission of this authorization form does not remove my responsibility to make timely payments for my health plan contribution which continues to be my sole responsibility; (4) if my automatic withdrawal is rejected by my bank due to insufficient funds or other circumstances, Secova will resubmit the automatic withdrawal once on the last Thursday of the month; (5) I am responsible for additional bank charges associated with insufficient funds; and (6) any automatic withdrawal not honored by my bank will be considered not paid and could result in cancellation of the corresponding health care coverage

Signature:	Date:

Attach a voided check (if for a checking account above) and mail or fax to SECOVA at the address on reverse side of this form.

FOOTHILL-DE ANZA
Community College District

SECOVA
Attn: RETIREES SUPPORT SERVICES
5000 Birch Street
West Tower, Suite 1400
Newport Beach, CA 92660

eFax: (877) 635-4606

Note: Please keep a copy for your records, including a copy of the fax confirmation page, if faxed.

For Secova Customer Service
Phone: (866) 364-2594
Email: fhda.retireebenefits@secova.com