FOOTHILL-DE ANZA
Community College District
Office of Human Resources and Equal Opportunity

KAISER PERMANENTE

UnitedHealthcare

Authorization for Automatic Withdrawal of Monthly Retiree Health Care Contributions for Kaiser and Self-Funded Plans Administered by UHC (EPO/PPO/Out-Of-Area)

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** UnitedHealthcare on behalf of FHDA to electronically withdraw the amount of my monthly retiree contribution payments from the designated checking or savings account listed below.

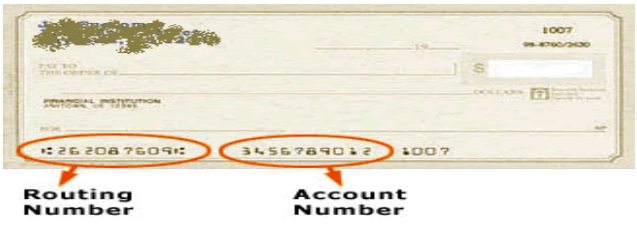
☐ **I understand** withdrawals will be made on the 1st of the month for which the payment is due (or on the next banking day if the 1st is a non-banking day). I further understand that this form may take up to 10 business days from the date received to process. If I am mailing this form close to the 1st of the month for which the premium payment is due, I will include a check for the monthly retiree contribution payment due on the 1st. Automatic withdrawals will then commence on the following premium payment due date.

☐ **I understand** that if my automatic withdrawal is rejected by my bank due to insufficient funds or other circumstances, UnitedHealthcare will resubmit the automatic withdrawal. Any automatic withdrawal not honored by my bank will be considered not paid and could result in cancellation of the corresponding health care coverage.

Note: Additional bank charges associated with each returned check/ACH withdrawal due to insufficient funds would be billed to the Retiree.

Name of Financial Institution

Mailing Address	City	State	Zip Code



Routing Number:

Account Number:

Type of Account ☐ Checking ☐ Savings

Requested Effective Date:

I understand automatic withdrawals will continue as the premiums come due until I either cancel this agreement by submitting the request *in writing* to UnitedHealthcare Benefit Services at the address below, **or** by cancelling my district-paid benefits. I agree that submission of this authorization form does **not** remove my responsibility to make timely payments for my retiree health plan contribution which continues to be my sole responsibility.

Signature:	Date:

Regardless of the health carrier you are insured with, you must send the form to UnitedHealthcare Benefit Services at the address and fax number provided below to authorize electronic fund transfers via ACH process. Attach a voided check and mail to:

UnitedHealthcare Benefit Services
P.O. Box 221709
Louisville, KY 40252

or fax signed form to: 1-866-525-1740 (keep a copy for your records and also keep the fax confirmation page)