



**AGREEMENT FOR PRE-AUTHORIZED
PREMIUM PAYMENTS (Debits) TO PAY RETIREE, or DIRECT BILL GROUP HEALTH AND/OR
DENTAL COVERAGE ON A MONTHLY BASIS**

I (we) authorize Employee Benefit Plan Administration, hereafter called **EBPA**, to withdraw (debit) the amount of my (our) monthly Retiree or Direct Bill group health and/or dental premium payment from my (our) checking or savings account indicated below and the **Financial Institution (e.g., bank, credit union, etc.)** named below, hereafter called **FINANCIAL INSTITUTION**, to debit the same to such account. Debits will occur within three (3) to five (5) banking business starting the first day of each month.

This debit is to be **EFFECTIVE**_____. **EMPLOYER:****COLUMBIA UNIVERSITY**

Please deduct the following premium(s) from my (our) checking or savings account:

- Checking account (attach a voided check to the bottom of this form)
- Savings account
(obtain the 9 digit ABA routing number from your bank)

Financial Institution Name:_____

City, State, ZIP:_____

Financial Institution Routing #_____ **Account #**_____

This authorization is to remain in full force and effect until **EBPA** has received written notification from me (or either of us) of its termination in such time and in such manner as to afford **EBPA** and **FINANCIAL INSTITUTION** a reasonable opportunity to act on it.

Name:_____ ID# _____

Address:_____ City, State, ZIP:_____

Signature_____ Telephone Number_____

Signature_____ Telephone Number_____
(Joint Account Holder)

If you have questions, call 1-888-232-3203
Please mail completed Authorization Form along with a **voided check** to:

**EBPA
P.O. Box 1316
Williston, VT 05495**