FOOTHILL-DE ANZA
Community College District

Office of Human Resources and Equal Opportunity

ACH Authorization Form

Authorization for both Debit/Credit for the Following Options: (1) Automatic Withdrawal of Monthly Retiree Health Care Contributions for Benefits Provided by CalPERS (Retirees Who are Non-PERS/STRS Annuitants); (2) DirectBill or BalanceBill Quarterly for Survivor's Contributions; (3) ACH Monthly Reimbursement for the Variance Between CalPERS Mandated Cost vs What the Unions Have Negotiated and (4) ACH Quarterly Medicare Part B Premium Reimbursement.

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

Participant Information

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

Please check all that apply:

☐ **I understand** that the Retiree's Monthly Reimbursement is for the Premium Variance between CalPERS mandated cost versus the Unions' negotiated monthly contribution, and that it is deposited directly to my bank. In an event that the account required an adjustment due to death or Medicare-eligibility, **I hereby authorize** Discovery Benefits 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** that my Quarterly Medicare Part B premium are processed by FHDA and deposited directly via ACH through Discovery Benefits

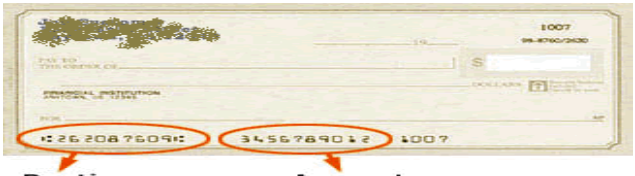
☐ **I understand** withdrawals will be made on the 1st of the month for which the payment is due (or on the next banking day if the 1st is a non-banking day). I further understand that this form may take up to 10 business days from the date received to process. If I am mailing this form close to the 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, Discovery Benefits will resubmit the automatic withdrawal once on the last Thursday of the month. 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 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. The same ACH form will also allow the District to reimburse me Monthly.

Signature:	Date:

Regardless of the health carrier you are insured with, you must send the form to FHDA at the address and fax number provided below to authorize electronic fund transfers via ACH process.

Attach a voided check and mail to:

Foothill-De Anza Community College District
Attn: Benefits Unit
12345 El Monte Rd
Los Altos Hills, CA 94022

or fax signed form to: 650-949-6299 (keep a copy for your records and also keep the fax confirmation page.)
You may also pdf the document and email to MyBenefits@fhda.edu.