



## South Central Service Cooperative ACH Authorization Form for Monthly Health Insurance Premiums

I authorize South Central Service Cooperative and the financial institution named below to automatically withdraw health insurance premiums via ACH from this organization's account listed below.

South Central Service Cooperative will not withdraw any amount different from the monthly Medica billing without written permission from the participating organization. Premium draws will take place on the first business day of each month.

Organization Name: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Financial Institution Name \_\_\_\_\_

Branch \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Bank Routing Number (9-digits) \_\_\_\_\_

Account Number \_\_\_\_\_

\_\_\_\_\_ *Checking Account*      \_\_\_\_\_ *Savings Account*

\_\_\_\_\_  
Print Name \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Phone Number \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_