



**AUTHORIZATION FOR DIRECT PAYMENT OF HEALTH INSURANCE PREMIUM**

I authorize the City of Racine to instruct my financial institution to deduct my health insurance premiums from my checking or savings account as noted below. If at any time I decide to change banks or discontinue this payment service, I will notify The City of Racine. I have enclosed a voided check from my checking account or the correct routing and account numbers from my savings account. I understand that payment will be deducted from my account on due dates as follows: March 1, June 1, September 1 and December 1.

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Daytime phone Number: \_\_\_\_\_ Email \_\_\_\_\_

**BANK INFORMATION:    Voided Check must be attached! (Deposit slips NOT acceptable)**

If your voided check is from a credit union or you are using a savings account to enroll in the Direct Payment Program, please provide the Routing Number and Account Number as supplied by your financial institution:

Financial Institution and Address \_\_\_\_\_

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

Deduct from Checking or Savings, please check one:

- Checking
- Savings

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**WE WILL NOTIFY YOU UPON RECEIPT OF THIS PAPERWORK. Please select your preferred method below. IF YOU DO NOT HEAR FROM US, WE HAVE NOT RECEIVED YOUR ENROLLMENT FORM – PLEASE CONTACT US!!**

- U.S. Postal System
- Email
- Telephone

Return to: City of Racine – Health Insurance Direct Payments  
730 Washington Avenue, Room 204  
Racine, WI 53403-1146

(262) 636-9148