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 or about due dates in early 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
Finance Department
730 Washington Avenue
Racine, WI 53403-1146

(262) 636-9148