SISC III
AUTOMATIC PAYMENT PLAN AUTHORIZATION

(Please retain photocopies of the signed documents for your records)

Please continue to pay by check until you receive notification that an auto payment will be taken

Before completing this form, read Terms of Agreement and make sure you understand the terms and conditions of the agreement. Sign and mail both completed forms to: **SISC Health Benefits Department, PO Box 1591, Bakersfield, CA 93302-1591.**

INSTRUCTIONS

1. Please complete, sign and date **both the Authorization and the Terms of Agreement form**. Return to SISC **with a voided check**. Omission of signature or other pertinent information on either form will delay processing. SISC will return the form to the member if it is incomplete.
2. Notify SISC immediately of any account changes or account closings. Please call our office for a new form to make changes or notify us of an account closure.
3. If you have any questions, please call (661) 636-4410 or 800-972-1727.
4. FAX (661) 636-4893.

TYPE OF TRANSACTION ☐ **NEW** ☐ **NEW** ☐ **CANCEL**
(Please identify change)

TO BE COMPLETED BY MEMBER: Effective Date_____
(It will take approximately 30 days for SISC to complete the initial set up)

INSURED'S NAME
ADDRESS STREET CITY STATE ZIP CODE
PHONE
CHECKING ACCOUNT ONLY (ATTACH UNSIGNED VOIDED CHECK)
FINANCIAL INSTITUTION
NAME(S) ON CHECKING ACCOUNT
ROUTING #
ACCOUNT#
PAYMENT WILL BE DEDUCTED ON THE 20th OF EACH MONTH

ACCOUNT HOLDER'S CERTIFICATION

I CERTIFY THAT I HAVE READ AND UNDERSTAND TERMS OF AGREEMENT. IN SIGNING THIS FORM, I AUTHORIZE THE REFERENCED ACCOUNT AT THE FINANCIAL INSTITUTION NAMED ABOVE TO BE DEBITED BY SISC FOR SISC III – HEALTH BENEFITS INSURANCE PREMIUM. THIS AUTHORIZATION REMAINS IN EFFECT UNTIL CHANGED OR CANCELED BY ME, MY FINANCIAL INSTITUTION OR SISC.

SIGNATURE √_____title/relationship to insured:_____

TYPE OR PRINT NAME_____ **Date:**_____

If person signing is not a signatory on the checking account, a copy of the Power of Attorney must be attached

SISC III
AUTOMATIC PAYMENT PLAN AUTHORIZATION
TERMS OF AGREEMENT
(Please retain photocopies of the signed documents for your records)

If you are participating in the SISC III – Health Benefits, you have the option of having your full monthly insurance premium debited directly from your checking account at your financial institution rather than paying by check. The following are the terms and conditions for participating in the Automatic Payment Plan Authorization program. You do not have to participate in the Automatic Payment Plan Authorization program in order to be a SISC III participating member. **This is an optional program.**

1. You must complete the Automatic Payment Plan Authorization form to enroll in the SISC Automatic Payment Plan Authorization program. Both forms (1) Automatic Payment Plan Authorization and the (2) Terms of Agreement must be signed dated and returned to the SISC office for processing. It is the member's responsibility to notify any other financial institution that payment will now be made by this method. SISC will not be responsible for any fees associated with insufficient funds if the member is currently using another method of payment such as bill pay through a financial institution.

2. It is your responsibility to notify the SISC Health Benefits Department immediately of any changes in your account, such as account closure or change in account number. You will be liable for any bank fees associated with failure to notify SISC in a timely manner of any changes in your account. Complete the Automatic Payment Plan Authorization form indicating the action is a CHANGE, and specify the new account information. If there is an interruption in the SISC Automatic Payment Plan Authorization service, you will be responsible for premium due during that time. Please call the SISC office for a form to indicate a change or to cancel to program.

3. SISC processes the automatic deduction on the 20th of each month. If the 20th falls on a weekend or holiday, the payment will be processed on the next available business day. The 20th of the month is the only option and the retirees cannot choose which date the funds will be withdrawn. SISC will only make one attempt at withdrawing the funds from your designated account. If an electronic transfer is returned to SISC, you will be responsible for not only the unpaid premium but also all processing fees charged to SISC. A fee of $35 will be assessed for each transaction that is rejected by the financial institution. Payment is considered made only if SISC actually receives funds.

4. Your participation in the Automatic Payment Plan Authorization program will automatically continue from one Plan Year to the next, unless you request cancellation. **Rates change on October 1st and this program will automatically change the rate that is transferred from your account.**

5. You may cancel your participation in the Automatic Payment Plan Authorization program at any time by completing the Automatic Payment Plan Authorization form indicating the action is a CANCEL. The cancellation will take effect approximately 30 to 45 days after the next Automatic Payment Plan Authorization cycle which occurs on the 20th of each month. Completion of the Automatic Payment Plan Authorization form will not cancel your medical/prescription coverage just the Automatic Payment Plan Authorization program.

6. This agreement may also be canceled by your financial institution or by SISC. SISC reserves the right to automatically cancel your participation in the Automatic Payment Plan Authorization program upon termination of SISC III membership.

I CERTIFY THAT I HAVE READ AND UNDERSTAND TERMS OF AGREEMENT. IN SIGNING THIS FORM, I AUTHORIZE THE DESIGNATED FINANCIAL INSTITUTION TO BE DEBITED BY SISC FOR SISC III – HEALTH BENEFITS INSURANCE PREMIUM.

SIGNATURE √_____title/relationship to insured:_____

TYPE OR PRINT NAME_____ **Date:**_____