RESEARCH FOUNDATION CUNY

RESEARCH FOUNDATION
of The City University of New York
230 West 41st Street
New York, NY 10036-7207

DIRECT DEBIT PAYMENT AUTHORIZATION AGREEMENT

Direct Debit Payment Services Conditions and Terms

- This enrollment form must be received at Research Foundation by the tenth (10th) day of the month preceding the month you wish to start direct debit. You will be notified if the direct debit process foryour account was not satisfactory.
- RF will request the transfer of direct debit funds once a month.
- J.P. Morgan-Chase will be authorized to debit funds from my bank account for deposit into the Research Foundation's account on the tenth (10th) working day of the month.
- The amount debited from my account will equal the current regular monthly health insurance payment. I understand that direct debit will not include additional fees, handling charges, etc.
- I am completely responsible for notifying the RF in writing, by the tenth (10th) of the preceding month, of any changes to my account (i.e. change of bank or account #'s). Failure to notify the RF by the tenth (10th) of the preceding month may result in funds being withdrawn in the following month. Any charges caused by this debiting and failure to notify the RF will be my responsibility.
- If I have two (2) insufficient funds (NSF) returns I will be ineligible to continue in the direct debit payment program.
- If a direct debit is not honored by my bank, I will be responsible for making up that payment (including NSF charges) by certified check. If I do not submit a check by the 30th of the month in which payment was due, my coverage may be terminated.
- I cannot change banks or accounts more than twice a year.

I am a　　Cobra participant　　Part Time A employee in the Direct Pay Program　　Employee enrolling a dependent up to the age of 29

I (We) authorize Research Foundation of CUNY to initiate debit entries to my (our) checking account as indicated below and the bank listed below to debit same account.

Bank Name ______________________________

Account# ______________________ Account Type (checking / savings) ______________

ABA/Bank Routing Number (always nine digits) Bank ______________________

Address ______________________________

City ______________________ State ______________

This authorization is to remain in full force and effect until Research Foundation of CUNY receives written notification from me (us) of its termination. Two signatures are required for joint accounts.

Name ______________________ Name ______________________

Signed ______________________ Signed ______________________

Phone ______________________ Phone ______________________

Date ______________________ Date ______________________

Please return this completed form with a voided check or pre-printed savings deposit slip to

Research Foundation of CUNY 230 West 41st Street 7th Floor New York, NY 10036

For Office Use

Start Date ______________________ Monthly Insurance Premium ______________

Participant ID# ______________________ Telephone ______________

RF Representative ______________________