Human Resources
550 S. College Ave., Suite 201
Newark, DE 19713
302-831-2171

DIRECT PAYMENT AUTHORIZATION

By completing and returning this form, you will establish an easy and less costly way of paying your benefit premiums to the University of Delaware. This authorization to debit your account will remain in effect until we receive written notification from you of its termination, and the University of Delaware has had reasonable opportunity to process your change. This debit will be recorded on your monthly bank statement. Please anticipate the first debit of funds from your account within 30-40 days after your return of this form. The University will provide you with at least 30 days notice of any increase in the amount of your benefit premium(s).

AUTHORIZATION AGREEMENT

I (We) hereby authorize the University to initiate debit entries to my (our) checking account indicated at the financial institution named below, to debit the same to such account.

Financial Institution: _____

Routing #: _____

Account#: _____

Benefit Plan	**Amount to Debit***
Health: _____	_____
Health: _____ (Second plan if needed)	_____
Dental: _____	_____
Vision: _____	_____

Effective Date: _____

***Deductions will be taken between the 10th and 15th of each month.**

This authorization is to remain in effect until the University of Delaware has received written notification from me (or either party of a joint account signing below) of its termination in such time and such manner as to afford the University of Delaware and the Depository a reasonable opportunity to act on it.

Name: _____
Please Print

Signature: _____ Date: _____

Please Note: Attach a pdf file or a scanned image of a voided check or bank statement on official bank letterhead including the transit and account numbers.

You must download this form to your computer to make it fillable.