Retiree Health Insurance Electronic Fund Transfer (EFT) Authorization Agreement

Multnomah County retiree health insurance premium payments will be made as an electronic funds transfer (EFT) withdrawal from a bank account.
This Agreement must be completed by the party responsible for making health insurance premium payments and from whose bank account funds will be withdrawn.
Responsible Party may be: 1) County retiree, 2) spouse, 3) domestic partner, or 4) fiscal administrator.

Retiree Name:

If premium payments will be made from the bank account of someone other than the retiree, complete the following:

Responsible Party Name:	
Social Security Number:	Relation:

1. I authorize Multnomah County to automatically withdraw funds from my checking or savings account at my designated Financial Institution for the purpose of paying monthly Multnomah County retiree health insurance premium(s) (medical and/or dental coverage).
2. I am responsible for immediately notifying Multnomah County of any change in my account information or financial institution. I understand failure to provide current account information and/or financial institution information to Multnomah County may result in a non-payment of the Multnomah County retiree health insurance premium and suspension of the insurance coverage.
3. I understand, if the County is required to initiate a collection process, I will be required to pay the County a penalty fee for the processing costs.
4. In the event of a Multnomah County retiree health insurance premium change, I authorize Multnomah County to initiate the change directly with the financial institution listed below.

A voided check or deposit slip must be attached to this form.

Financial Institution: ______________________________

ACH Routing #: ____________________ Account #: ____________________

Check One: Checking Account
Savings Account

Month/Year of First Withdrawal: ____________________

This authorization remains in force until I provide Multnomah County with **written notification** to change the information or end the EFT. My written notification must be provided to Multnomah County in a timely manner and cannot be implemented retroactively.

Signature of Responsible Party: ______________________________ Date: __________

Typing your name and attaching form to an email is allowable for esignature.

Return to:
Retiree.benefits@multco.us
Fax: 503-988-6257
Multnomah County Benefits, 501 SE Hawthorne, Ste 320, Portland, OR 97214