Human Resources Department
Benefits, Workers' Compensation
Occupational Health and Safety Division
121 7th Place East, Suite 2100
St. Paul MN 55101

Direct Payment Authorization Form

Ramsey County is pleased to offer you a new service- the Direct Payment Plan. Now you can have your retiree insurance payment deducted automatically from your checking or savings account. You won't have to change your present banking relationship to take advantage of this service.

The Direct Payment Plan will help you in several ways:

- It saves time – fewer checks to write and mail.
- Helps pay your bills in a convenient and timely manner – even if you're on vacation.
- Your payment is always on time helping maintain good credit.
- Easy to sign up for, easy to cancel.
- No late charges.

Here's how the Direct Payment Plan works:
You authorize regularly scheduled payments to be made from your checking or savings account. Then, just sit back and relax. Your quarterly invoiced payment (full amount due) will be made automatically on the date specified on the invoice. Proof of payment will appear on your bank statement. The authority you give to charge your account will remain in effect until you notify Ramsey County, in writing, to terminate the authorization. If the amount of your payment changes, Ramsey County will notify you at least 10 days before the payment date. The Direct Payment Plan is dependable, flexible, convenient and easy. To take advantage of this service, complete the attached authorization form and return it to us.

All you need to do is:

1) Mark the box before the type of account to indicate whether your payment will be deducted from your checking or savings account.
2) Provide your name, signature, financial institution name and location, and date.
3) Attach a voided check. If you are unable to attach a voided check, please fill in your account and routing numbers.

NOTE: Be sure to sign the form!

Please complete the information below

I authorize Ramsey County to initiate electronic debit entries to my:

_____ checking account (or) _____ savings account

for payment of my Retiree Medical/Dental Premium.

I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until I have cancelled it in writing.

NAME (PLEASE PRINT) _____

SIGNATURE _____ DATE _____

FINANCIAL INSTITUTION NAME (PLEASE PRINT) _____

FINANCIAL INSTITUTION CITY AND STATE _____

COMPLETE BELOW ONLY IF YOU DO NOT PROVIDE A VOIDED CHECK

ACCOUNT NUMBER AT FINANCIAL INSTITUTION _____

FINANCIAL INSTITUTION ROUTING NUMBER (9 digits) _____