DIRECT DEPOSIT ENROLLMENT FORM
Authorization to Receive Reimbursements by Direct Deposit (ACH Credit)

Your health premium reimbursements may be deposited directly into your account. If you wish to enroll, please complete this form, **and return with a copy a "voided" check to the address listed at the bottom**.

Check one: ☐ Initial enrollment ☐ Change existing enrollment

Name:	Last 4 of SSN:
Mailing address (complete with street, city and zip):	Contact Information (Phone and/or Email)

For Initial Enrollments Only:

☐ Use the same direct deposit account on file with payroll at time of retirement for my health reimbursement.

☐ **Do Not** use the same account on file with payroll at time of retirement for my health reimbursement.

Account Information.

To ensure that the correct account is transferred. Please complete the information below regardless of your selection above.

Name of Financial Institution: _____

Branch Address:_____ City/State/Zip:_____

Account Type: ☐ Checking OR ☐ Savings

Bank Routing #: ____ ____ ____ ____ ____ ____ ____ ____ ____ Account #:_____

I, the undersigned, hereby authorizes Cosumnes Community Services District, hereinafter called the DISTRICT, to deposit my health premium reimbursements directly into my account until I give further written notice. I understand that it may take up to 72 hours from the time the DISTRICT processes my payment for the funds to post to my designated bank account. I also grant the DISTRICT the right to correct any electronic fund transfer resulting from an erroneous overpayment by debiting my account to the extent of such overpayment. This authorization will remain in full effect until the DISTRICT has received written notification from me of its termination in a time and manner that affords the DISTRICT and the Financial Institution a reasonable opportunity to act.

_____
Print Name

_____ _____
Signature Date

Send completed form to:
Cosumnes Community Services District
8820 Elk Grove Blvd., Elk Grove, CA 95624
Fax: (916) 512-6230