AUTOMATED PAYMENT SYSTEM

The Automated Payment System is an optional program for retirees and COBRA participants who prefer to have their monthly health insurance premiums automatically deducted from their bank account. Premiums are generally deducted from your account during the second week of each month for that month's coverage.

If you wish to participate in this program, please **complete and return the authorization below** to Clackamas County Benefit, 2051 Kaen Rd, Ste 310, Oregon City, OR 97045. Attach a **voided check for a checking account or deposit slip for a savings account** to the completed authorization form. Allow four to six weeks for processing. Until then, please continue to send your payments to our office.

You will be notified in writing in advance of any future **premium increases or decreases** which will be reflected in a new automatic payment amount. It is not necessary to complete a new authorization form each time there is a change in premium.

If you **change banks or account numbers**, you must complete a new authorization form and provide a new voided check or deposit slip. Again, allow four to six weeks for processing.

You may **cancel your automatic payment** at any time by notifying the County in writing. Allow enough time for the County and your bank to process your request.

If you do not wish to enroll in the Automated Payment system at this time, you may do so at a later date.

If you have any questions about the Automated Payment System, or wish to request additional forms, please contact Clackamas County Benefits at 503-655-8459.

AUTHORIZATION FOR AUTOMATIC PAYMENT OF INSURANCE PREMIUMS

I hereby authorize CLACKAMAS COUNTY to charge my checking or savings account listed below for payment of monthly health care premiums. I also authorize my financial institution listed below to honor these monthly charges against my:

☐ CheckingAccount **(attach a voided check)**
☐ Savings Account **(attach a deposit slip)**

_____
Routing Number

_____
Account Number

_____
Name of Financial Institution (Bank/Credit Union/Other)

This authorization will remain in effect until I give notice in writing to CLACKAMAS COUNTY and my financial institution revoking this authorization. I understand that I must give notice of revocation in sufficient time in advance to allow CLACKAMAS COUNTY and my financial institution a reasonable opportunity act upon my revocation.

_____ _____
SIGNATURE DATE

_____ _____
NAME (please print) EMAIL

_____
STREET ADDRESS

_____
CITY STATE ZIP

PLEASE ATTACH A VOIDED CHECK FOR CHECKING ACCOUNT OR DEPOSIT SLIP FOR A SAVINGS ACCOUNT.