



South Central Service Cooperative ACH Authorization Form for Monthly Health Insurance Premiums

I authorize South Central Service Cooperative and the financial institution named below to automatically withdraw health insurance premiums via ACH from this organization's account listed below.

South Central Service Cooperative will not withdraw any amount different from the monthly Blue Cross/Blue Shield billing without written permission from the participating organization. Premium draws will take place on the first business day of each month.

Organization Name: _____

Address _____ City _____ State _____ Zip _____

Financial Institution Name _____

Branch _____ City _____ State _____

Bank Routing Number (9-digits) _____

Account Number _____

_____ *Checking Account* _____ *Savings Account*

Print Name

Date

Phone Number

Authorized Signature

Date