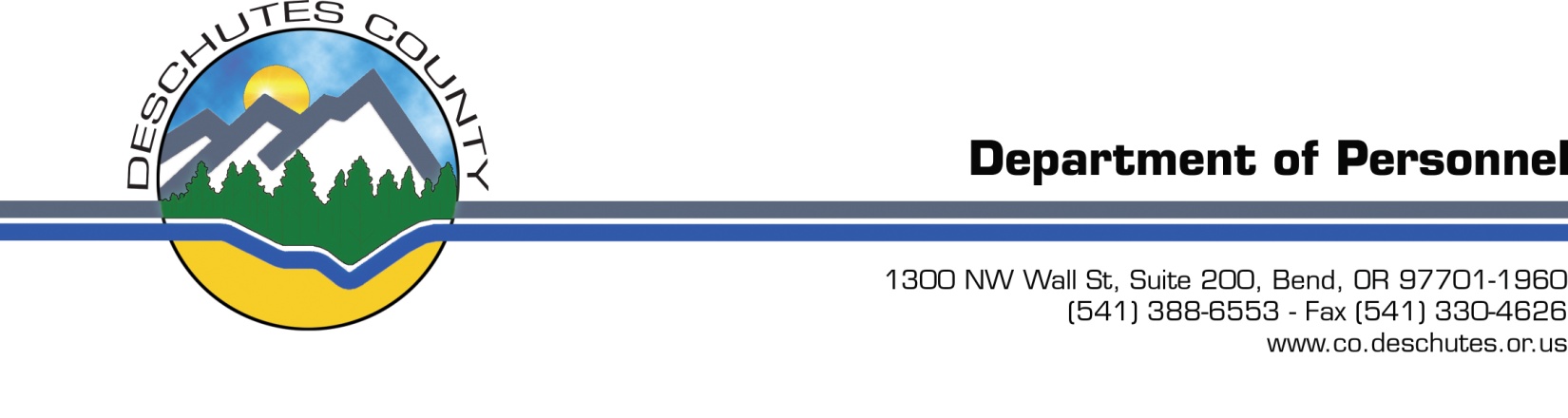
**Credit/Debit Card Payment Authorization Form**

***Retiree Health Benefits*** 

Instructions: Complete all shaded areas, sign and date this form

All transactions for the current month’s coverage must be concluded by10th of the month. Transactions unable to be resolved by the 10th of the month may result in coverage termination.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of Retiree | | | Phone number | | |
| Billing Address | | | | | |
| Card Type (circle one): Visa MasterCard Discover | | | | | |
| Card Number (16 digits) | | | | Expiration Date (mo/yr) | |
| Print name as it appears on your card | | | | | |
| Email address (if you would like an email sent to you confirming charge) | | | | | |
| County use only: | | | | | |
| Monthly payment amount | | Staff initials | | |
| Start Date |

I authorize Deschutes County to Charge my credit or debit card for that portion of the Deschutes County Retiree health insurance premium, which is the responsibility of the retiree. The Retiree’s portion of the insurance premium in affect upon signing is $\_\_\_\_\_\_\_\_ per month. The Retiree’s monthly insurance premium is subject to increase or decrease annually, based on the adoption of the County budget. Without further notice from the Deschutes County I authorize the County to change the monthly insurance amount charged to my credit or debit card based upon premium adjustments, as long as I continue with the Deschutes County Health Benefits Plan.

This authorization will remain in effect until I notify the Deschutes County Personnel Department of my intention to cancel. Such notice must be provided at least ten days before the next scheduled payment. I understand that I must notify the Deschutes County Personnel Department if I change, close, or modify the account information listed on this form. I accept responsibility for the accuracy of all information that I have provided on this form and understand that continuation of my health benefits depends upon timely payment of premiums. I acknowledge that the origination of these electronic transactions to my account must comply with the provisions of U.S. law.

**Signature** **of Cardholder**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Retiree**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(if different than cardholder)**

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