

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED HEALTH AND/OR
DENTAL INSURANCE PAYMENTS
(ACH DEBITS)

I hereby authorize University of Louisiana at Lafayette to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my checking or savings account and the depository named below to debit and/or credit the same to such account for the purpose of making health and/or dental insurance payments. I authorize UL Lafayette to make such entries (select one):

monthly
 quarterly
 annually

In the case of preauthorized variable amount debits, I request that UL Lafayette give me ten (10) days prior written notice of any rate increases.

Fill in information below or attach a voided check.

Depository/Bank name _____

Transit ABA/Number _____

Account Number _____

Select one Checking account Savings account

This authority is to remain in full force and effect until University of Louisiana at Lafayette has received written notification from me of its termination in such time and in such manner as to afford University of Louisiana at Lafayette and the depository a reasonable opportunity to act on it.

Name _____

SSN _____

Signature _____ Date _____