



**AGREEMENT FOR PRE-AUTHORIZED
PREMIUM PAYMENTS (Debits) TO PAY COBRA, RETIREE, or DIRECT BILL GROUP HEALTH
AND/OR DENTAL COVERAGE ON A MONTHLY BASIS**

I (we) authorize Employee Benefit Plan Administration, hereafter called **EBPA**, to withdraw (debit) the amount of my (our) monthly COBRA, Retiree or Direct Bill group health and/or dental premium payment from my (our) checking or savings account indicated below and the **Financial Institution (e.g., bank, credit union, etc.)** named below, hereafter called **FINANCIAL INSTITUTION**, to debit the same to such account. Debits will occur the first business day of each month. This debit is to be **EFFECTIVE** _____.

EMPLOYER - NYU

Please deduct my monthly premium(s) from my (our) checking or savings account
All premiums for health and/or dental will be debited from the same account.

- Checking account (attach a voided check to the bottom of this form)
- Savings account
(obtain the 9 digit ABA routing number from your bank)

Financial Institution Name: _____

City, State, ZIP: _____

Financial Institution Routing # _____ **Account #** _____

This authorization is to remain in full force and effect until **EBPA** has received written notification from me (or either of us) of its termination in such time and in such manner as to afford **EBPA** and **FINANCIAL INSTITUTION** a reasonable opportunity to act on it.

Name: _____ ID# _____

Address: _____ City, State, ZIP: _____

Signature _____ Telephone Number _____

Signature _____ Telephone Number _____
(Joint Account Holder)

If you have questions, call 1-800-258-7298, option #3
Please mail completed Authorization Form along with a **voided check** to:

**EBPA
P.O. Box 1150
Exeter, NH 03833-1150**