



## ***AUTOMATIC BILLING AUTHORIZATION FORM***

Company Name: Puyallup School District Employee Name: \_\_\_\_\_

Employee #: \_\_\_\_\_

**Purpose: SELF PAY FROM CREDIT CARD:**

I authorize you to charge my bill directly to the credit card listed below on the **5<sup>th</sup> of each month or the next business day** for that month's medical and/or dental coverage: I understand there will be \$1.25 convenience fee each month.

**Credit Card:**

\_\_\_\_\_  
Name on credit card (exactly as printed) Email (required for payment confirmation to be sent)

\_\_\_\_\_  
Billing Address for credit card (Street, Apt. #) Phone number

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Credit card number Expiration Date 3-digit CVV number on back of card

Bill all charges to the above card per my billing arrangement with Puyallup School District Benefits office.

If there is a change in the payment amount, I will receive notification from the Benefits office prior to the next scheduled transaction date.

This authorization is valid until I provide you with written cancellation.

Insufficient funds within the account or failure to pay in a timely manner will result in cancellation of your coverage and/or referral to a collection agency.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

Please return completed form to: Puyallup School District, PO Box 370, Attention Benefits Office, Puyallup, WA 98371

If you have any questions, please call 253.841.8615