PUYALLUP
SCHOOL DISTRICT

A Tradition of Excellence

Timothy S. Yeomans, Ed.D., Superintendent

AUTOMATIC BILLING AUTHORIZATION FORM

Company Name: Puyallup School District **Employee Name:**________________________________

Employee #: ____________________________________

Purpose: COBRA/SELF PAY

FROM CREDIT CARD:

I authorize you to charge my bill directly to the credit card listed below on the **1st of each month or the next business day** for that month's medical and/or dental coverage:
I understand there will be $1.65 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