STEUBEN COUNTY – MEDICAL INSURANCE PREMIUM
AUTHORIZATION AGREEMENT FOR ELECTRONIC (ACH) PAYMENTS

I (we) hereby authorize Steuben County, to initiate electronic withdrawals from my (our) bank account indicated below and to credit the same to the account of Steuben County about the 1st of each month in payment of:

_____ Medical Insurance Premium Description_____ (deducted around the 1st of each month)

_____ Other: _____ $_____ (to be deducted _____)

Name (print) _____

Address _____

_____ State ____ Zip _____

Phone #(s)_____

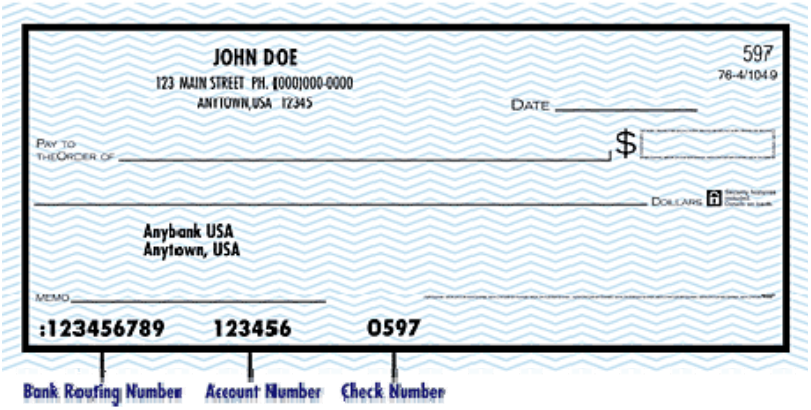
Bank _____

Account Number_____

Account Type _____Checking _____Savings

Routing Number _____

NOTES:



This authorization is to remain in full force and effect until Steuben County has received written notification from me (or either of us) of its termination. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Signature (s) _____ Date_____