Retiree Annual Vision Premium

AUTHORIZATION AGREEMENT FOR AUTOMATIC DRAFT
FOR RETIREE VISION PREMIUMS

I authorize McGriff to initiate a one time **electronic draft** from my authorized bank account **on** January 1st **for the annual cost of my** Retiree Vision **coverage. I have the right to stop Automatic Direct Draft of my payments by sending written request to McGriff at the address below, at least 30 days before the date my account is drafted.**

*Name:_____ *Employee ID/SSN:_____
(Print your Name)

*Telephone ( ) _____ Email Address: _____

*Street Address: _____

*City/State/Zip: _____

U.S. Bank Name/Branch _____

*Account Type (please check one): ☐ Checking ☐ Savings

*Bank Transit Routing No.: _____ *Account No.: _____
(First 9 digits encoded on bottom of check)

*Signature: _____ *Date: _____

Return Signed Agreement WITH VOIDED CHECK to:
McGriff Insurance - Emory
PO Box 896881
Charlotte, NC 28289-6881
Or Email to Lauren.Rice@McGriff.com
If you have questions, please call (678) 367-3107