



Retirement Date: _____

Coverage Elected: _____

**AUTHORIZATION AGREEMENT FOR AUTOMATIC DRAFT
FOR RETIREE MEDICAL AND/OR DENTAL PREMIUMS**

I authorize McGriff to initiate electronic draft entries on my checking or savings account for the cost of my healthcare and/or dental coverage. I understand I will not receive advance notification of a change in the draft amount if the change is to collect outstanding charges or is a result of a change in coverage I have elected. I also acknowledge that my cost of healthcare and/or dental coverage may change and I will be notified by Emory of any changes at the same time that my bank or financial institution is notified. **I understand the amount will be drafted on the 5th of each month, unless I am notified in advance of a change in the due date. 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. I understand that after stopping my Automatic Direct Draft my healthcare and/or dental coverage will terminate.**

I understand that Emory University and/or Emory Healthcare reserve the right to end this payment plan and my participation therein. If a payment due date falls on a weekend or bank holiday, I understand that the debit entry on my checking or savings account will occur on the next business day.

*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