PENN CAMBRIA SCHOOL DISTRICT

Excellence in Public Education

ACH Requirement for Medical/COBRA Premium Payments

Administration Office
201 6th Street
Cresson, PA 16630
(814) 886-8121
(814) 886-4809 (Fax)

High School
401 Linden Avenue
Cresson, PA 16630
(814) 886-8188
(814) 884-3977 (Fax)

Middle School
401 Division Street
Gallitzin, PA 16641
(814) 886-4181
(814) 886-9308 (Fax)

Intermediate School
376 Wood Street
Lilly, PA 15938
(814) 886-8532
(814) 886-5389 (Fax)

Primary School
400 Main Street
Lilly, PA 15938
(814) 886-2151
(814) 886-5419 (Fax)

Pre-Primary School
205 6th Street
Cresson, PA 16630
(814) 886-8166
(814) 886-4809 (Fax)

Payments to Penn Cambria School District for medical or COBRA premiums are required to be made monthly via ACH (Automatic Clearing House). In order to authorize these payments, you must complete a "Direct Debit Payment Authorization Form" (enclosed), with an original voided check attached. The voided check will allow us to validate your bank account information.

Your authorization will remain in full force and effect until the District receives written notification from you of its termination.

Our current guidelines require payments be made by the 15th of each month; therefore, we will automatically debit your authorized account for the amount due *on or after* the 15th of each month for the next month's premium.

Your authorization form must be received by the 1st of the month (prior to the month of coverage) in order to process your first payment. (Example: we must receive the authorization form by July 1st to process your August premium payment *on or after* July 15th.)

Questions may be directed to Payroll/Benefits at 814-886-8121 x1008.

DIRECT DEBIT PAYMENT AUTHORIZATION FORM

Company Name Penn Cambria School District Company Tax ID # 25-1157907

I authorize PENN CAMBRIA SCHOOL DISTRICT, hereinafter called COMPANY, to initiate debit entries to my **Checking Account** indicated below at the depository financial institution named below, hereinafter called DEPOSITORY. Also, if necessary, initiate adjustments for any transactions debited in error.

Depository
Bank Name _____ Branch _____

City _____ State _____ Zip _____

Routing/Transit Number _____ Account No. _____

This authorization will remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Customer
Name _____ SSN _____
PLEASE PRINT

Customer
Signature _____ Date _____

OPTIONAL:
Depository Bank Verification: _____ Date: _____
SIGNATURE OF BANK REPRESENTATIVE

NOTE: IN THE CASE OF REVOKED AUTHORIZATION, ALL WRITTEN AUTHORIZATIONS MUST BE REVOKED ONLY BY NOTIFYING THE ORIGINATOR (COMPANY) IN WRITING NO LATER THAN 15 DAYS BEFORE THE NEXT TRANSACTION EFFECTIVE DATE.

A VOIDED CHECK MUST BE ATTACHED TO THIS FORM. STAPLE VOIDED CHECK BELOW and RETURN TO:

Payroll/Benefits
Penn Cambria School District
201 6th Street
Cresson, Pa 16630-1363

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