



Adjunct Recurring Payment Election Form

Please see reverse side for instructions

University Benefits Office
City University of New York
555 West 57th Street - 11th Floor
New York, NY 10019

CUNYfirst Empl ID: _____

Full Name: _____
(Your Name as it appears on Bank Statements)

College 1: _____

Personal Email: _____

College 2: _____

Banking Institution: _____

Routing Number: _____

- Checking Account (Attach Voided Check)
- Savings Account (Bank Signature Required)

Account Number: _____

Amount to be deducted monthly: _____

For savings accounts, and checking accounts without a voided check:

As a representative of the above named financial institution, I certify that this institution is ACH capable and agree that payments can be remitted from the account shown above.

(Bank Rep's Printed Name)

(Bank Rep's Signature)

(Bank Rep's Telephone Number)

Employee/Joint Account Holders Certification: I certify that I have read and understand this form. By signing this form, I authorize my health insurance costs to be deducted from the account listed on this form. The joint account holder(s) for the account listed, if any, must sign on the corresponding line(s) for additional account holder(s).

Employee Signature: _____

Date: _____

Joint Account Holder: _____

Date: _____

Joint Account Holder: _____

Date: _____

By signing below, I certify that I permit the City University of New York to electronically withdraw funds from the above mentioned account to cover the expenses of my health insurance premiums, if any, based on the Adjunct Health Insurance Rate Sheet. I fully understand that the funds will be deducted from my account on a monthly basis on the first business day of the month preceding the period of coverage for which I am paying or the next possible administratively feasible date. I understand and agree that I am responsible for any fees associated with transactions due to insufficient funds in my account. I authorize the modification of deductions from my account due to future changes in expenses, including but not limited to premium rate and administrative fee changes, changes to my insurance made by me during the open enrollment period, and family status changes, in order to keep my health insurance current.

I, _____, agree to the terms above, and I am fully aware that failure to remit payment according to these terms may result in the termination of my health insurance coverage.

(Employee Signature)

(Date)

Adjunct Recurring Payment Election Form Instructions

This form should be completed by eligible Adjunct faculty members who are enrolling in a health plan for which premiums are required to be paid. This form, along with all the other required documents and forms to enroll in the New York City Health Benefits Program and the PSC/CUNY Welfare Fund Supplemental Benefits must be completed and submitted to your college Benefits Officer. If you are electing to have funds deducted from your checking account, you will need to include a voided check with this form. If you are electing to have funds deducted from your savings account, or a checking account for which you do not have a voided check, you are required to obtain a bank representative's signature in the space provided on this form. Please carefully follow the instructions below to complete this form.

1. Enter your CUNYfirst Empl ID and the Semester/Year for which you are applying for benefits in the spaces provided at the top of the form.
2. Enter your full name as it appears on your bank statements in the space provided for "Full Name".
3. Enter the name of the college(s) at which you are employed in the space(s) provided.
4. Enter your personal email address in the space provided.
5. Enter the name of your bank in the space provided for "Banking Institution".
6. Enter the nine digit Routing Number for your bank as it appears at the bottom of your personal checks or savings account deposit slips.
7. Fill in the radio button that corresponds with the account from which you wish to have your payments deducted.
8. Enter the Account Number from which you wish to have your monthly premium remittance withdrawn in the space labeled "Account Number".
9. Enter premium amount to be paid monthly in the space provided. Please refer to the rate sheet on the UBO website. <http://www.cuny.edu/benefits>
10. If the account listed is a joint account, you and the joint account holder(s) must complete the Employee/Joint Account Holders Certification section by signing and dating the form in the spaces provided.
11. Carefully read the terms of automatic recurring payments.
12. Print your name in the space provided.
13. Sign and date the form at the bottom of the document in the space provided.