

**DIOCESE OF SIOUX CITY  
AUTHORIZATION AGREEMENT  
Lay Health Insurance Premium  
FOR AUTOMATIC WITHDRAWALS (ACH DEBITS)**

**NAME of Location:** \_\_\_\_\_

**CITY of Location:** \_\_\_\_\_ **Location #:** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_

**CITY, STATE, ZIP:** \_\_\_\_\_

I hereby authorize The Diocese of Sioux City to initiate debit entries for monthly premiums for the Lay Health Insurance Program from the bank account listed below. Recurring electronic withdrawals will be processed for the amount of the unpaid invoice(s) as of the 13th of the month. Withdrawals will be made on the 15th or next business day of the month. This includes authorization to reverse any entries made in error.

**Financial Institution Name:** \_\_\_\_\_

**Financial Institution Location:** \_\_\_\_\_

**Transit/ABA Number:** \_\_\_\_\_

**Account Number:** \_\_\_\_\_

\_\_\_\_ Checking      \_\_\_\_ Savings

The authority is to remain in full force until The Diocese of Sioux City has received written notification of its termination in such timely manner as to afford the Diocese and the Financial Institution a reasonable opportunity to act on it.

**Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Date:**

Bookkeeper Contact Info:

Bookkeeper Name: \_\_\_\_\_ Email: \_\_\_\_\_

Bookkeeper Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please submit this form and a voided check  
(or photocopy of a check) to  
Marilyn Wellman at [marilynw@scdiocese.org](mailto:marilynw@scdiocese.org)  
or fax to: 712-233-7598**

Contact Diane at 712-233-7594 or Marilyn at 712-233-7518 if questions. Thanks.