**DIOCESE OF SIOUX CITY**

**AUTHORIZATION AGREEMENT**

**Priest Health Insurance Premium**

**FOR AUTOMATIC WITHDRAWALS (ACH DEBITS)**

**PRIEST'S NAME:** _____

**ADDRESS:** _____

**CITY, STATE, ZIP:** _____

I hereby authorize The Diocese of Sioux City to initiate debit entries for monthly payments for the Priest Health Insurance Program from the bank acccount listed below. Recurring electronic withdrawals will be processed for the monthly invoice on the 22nd or the next business day of the month. This includes authorization to reverse any entries made in error.

Parish Name: _____

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 or fax to: 712-233-7598**

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

#N/A