PEBA
SC Retirement Systems and State Health Plan

South Carolina Public Employee Benefit Authority
Serving those who serve South Carolina

Authorization Agreement for Electronic Funds Transfer

Your entity hereby authorizes the South Carolina Public Employee Benefit Authority and your bank named below to begin the automatic monthly deduction from your checking account for all insurance premiums due.

Bank name _____

City _____ State_____ Zip code _____

Bank phone _____

Transit routing number _____

Bank account number _____

This authorization will remain in effect until your bank has received written notification from PEBA to stop the deduction.

Your entity has the right to stop the deduction by written notification or personal visit to your bank prior to drafting the account. Your bank must receive the notification within five business days to allow your bank a reasonable opportunity to act on the request. If your group stops the deduction without written notification to PEBA, we will not allow your group to return to EFT.

Name of authorized signatory _____

Title of authorized signatory _____

Signature _____ Date _____

Employer group number _____ Phone _____

Instructions for completing the Authorization Agreement

1. **Bank name**: Enter the name of the bank where your group does business.
2. **City, State and Zip code**: Enter the address of the bank where your group does business.
3. **Bank phone**: Enter the telephone number of the bank where your group does business.
4. **Routing transit number**: Enter the 9-digit number preceding your bank account number.
5. **Bank account number**: Enter your bank account number.
6. **Name of authorized signatory**: Print the name of the authorized signatory for the account and sign in the space provided.