County of Santa Cruz

HUMAN RESOURCES DEPARTMENT

AJITA PATEL, DIRECTOR

701 OCEAN STREET, SUITE 510, SANTA CRUZ, CA 95060-4073

(831) 454-2600 FAX: (831) 454-2245 TDD: 711

RETIREE DIRECT DEPOSIT AUTHORIZATION

Retiree Health Insurance Reimbursement Program

Retiree Name: _____ **Phone Number:** _____

Mailing Address: _____

Email: _____

☐ Please enroll me in the Direct Deposit Option with the County of Santa Cruz for the Retiree Health Insurance Reimbursement Program. **(Fill in Bank Information Below)**

BANK INFORMATION

Bank Name:	City:	State:

☐ Checking
☐ Savings

Account#

IMPORTANT NOTES:

- **You MUST attach a void check or a bank statement** which shows your name and account number and return it to *Personnel Department, Retiree Health*. Deposit slips and handwritten backups **are not** acceptable, even if issued by your bank.
- Your monthly reimbursements are generally posted by the first day of the month.
- The total amount of your reimbursement will be directly deposited into one designated account.
- You will continue to receive a reimbursement check for the next month after this form is processed. On the second (2) month, your reimbursement should be a direct deposit to your designated bank account.

Please call (831) 454-3155 or email us at RetireeBenefits@santacruzcountyca.gov for question or concerns regarding your Retiree Health Reimbursements

I hereby authorize the County Auditor's Office to automatically deposit my Retiree Health Insurance Reimbursement to the account designated above. This authority will remain in effect until I notify the County Auditor's Office in writing of its termination.

_____

Retiree Signature (or Power of Attorney – must supply documentation) **Date**