



**Mailing Address:**  
1000 Chastain Rd., #3501  
Kennesaw, GA 30144

## Direct Debit Authorization

I hereby authorize Kennesaw State University to automatically deduct my monthly insurance premium payments from my checking account. I understand I must have sufficient funds in the account each month on the date due to cover the amount of the automatic deduction. I further agree to reimburse Kennesaw State University for returned check charges should there not be sufficient funds in the account.

Any changes should be reported to the Benefits Office, in writing, at least 30 days prior to a scheduled deduction. If the premium amount changes, you will be notified of the new amount before the next automatic deduction.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Current Phone Number

\_\_\_\_\_  
Signature

Please attach a voided check to this form so we can identify account and bank routing number.