



Dear Henrico County Retiree:

If you are enrolled in Southern Health, you have the option of mailing in your monthly premium payment or having it directly drafted each month from a checking or savings account.

To MAIL in your premium payments:

Once you are enrolled in the health coverage you will receive monthly invoices.

To have your premiums paid by DIRECT DRAFT from a checking or savings account:

Once you are enrolled in the health coverage your premium will be deducted monthly on the 10th of the month. (If the 10th of the month falls on a Bank Holiday then your account will draft on the next business day).

1. Complete the Automatic Transfer System (ATS) Authorization Form on reverse;
2. Attach a VOIDED check for the account of your choice;
3. Sign and date the ATS form;
4. If you are a **NEW** Southern Health member please return the ATS form and VOIDED check WITH your health Enrollment Form to your Human Resource/Health Benefits Department.
5. If you are a **current** Southern Health member please mail your ATS form to:

SCHOOLS RETIREE:

**Henrico County Public Schools
P. O. Box 23120
Henrico, VA 23223
Attention: Health Benefits**

GOVERNMENT RETIREE:

**Henrico County General Government
Human Resources Department
P. O. Box 90775
Henrico, VA 23273-0775
Attention: Benefits Division**

Please allow 45 days for your Direct Draft information to be processed. If you are currently in a Direct Billed Group and receive invoices, please pay any invoices received. Your Benefits Office will forward your Direct Draft information to Southern Health. Once your Direct Draft information has been received by Southern Health, you will be moved to a Direct Draft group and a new ID card to be mailed to you. Please continue to use your current card until your new one has been received.

- - - Please see Reverse for Automatic Transfer System (ATS) form. - - -

HENRICO COUNTY

Automatic Transfer System (ATS) Authorization Form

I authorize **Southern Health** to deduct monthly premium payments from the account identified below.

Name of covered person:	Social Security #	Phone number: ()
Name of bank or savings institution: (cannot be a passbook account)	Account number:	
Address of bank or savings institution: Street Address	City	State Zip
Name of bank account holder:	Social Security #	Phone number: ()
Address of bank account holder: Street Address	City	State Zip
Signature of bank account holder:	Date	
For Southern Health Use Only		
ABA Routing Number	Effective Date of ATS	Member Number

*Please attach **VOIDED CHECK** here.*

----- *Please see instructions on the reverse.* -----