J.J. STANIS AND COMPANY, INC
377 OAK STREET, SUITE 406 GARDEN CITY, NY 11530
PHONE: (516) 465-3900 FAX#: (516) 465-3920 WEBSITE: WWW.JJSTANISCO.COM

NORWICH CSD AUTOMATIC PREMIUM DEDUCTION AUTHORIZATION FORM

I, _____ request the withdrawal of my monthly ☐ Medical **and/or** ☐ Dental
(print your name)

Insurance Premium from my (◯ Checking / ◯ Savings) account number _____

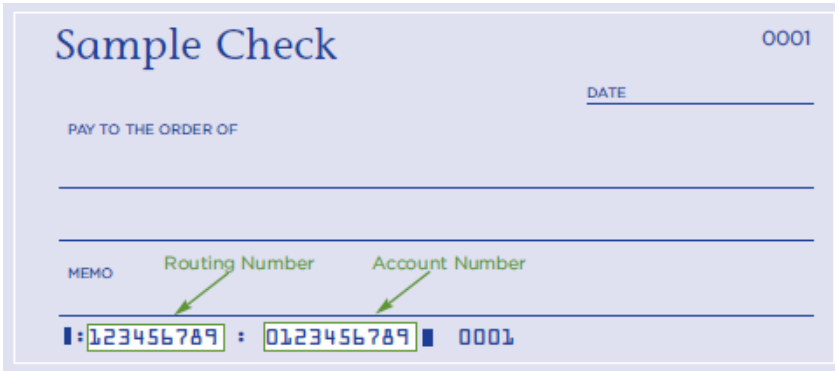
_____ _____
(Bank routing number) **(Account number)**

with _____bank, effective _____.
(Name of Bank) **(Date you want to begin deduction)**

My current monthly amount is $_____

Note: The amount authorized will be deducted from your account monthly on or about the 1st of each month.

ATTACH A COPY OF A VOIDED CHECK HERE:



Amount authorized above will continue to be withdrawn until written notice is received by J. J. Stanis and Company, Inc. indicating a termination date of further withdrawals.

Signature: _____ **Date:** _____

Member ID Number or Social Security Number: _____

Mailing Address: _____

Phone Number: _____

Mail this form and a copy of a VOIDED check to:

J. J. Stanis and Company, Inc.
Attention: Retiree Billing
377 Oak Street, Suite 406
Garden City, NY 11530