LAKE HAVASU UNIFIED SCHOOL DISTRICT #1
2200 Havasupai Blvd, Building C,
Lake Havasu City, AZ 86403
Phone 928-505-6930

Name: _____ Phone: _____

Address: _____ Email: _____

City: _____ State: _____ Zip Code: _____

RE: AUTHORIZATION TO DEBIT BANK ACCOUNT FOR RETIREE INSURANCE PREMIUM AUTOMATIC PAYMENT PLAN

Please attach a copy of a **VOIDED CHECK**:
Return to Payroll at the above address.

Bank: _____

Account Holders Name: _____

Routing Number: (9 digit number on bottom left of check) _____

Account Number: (To the right of the routing number) _____

Type of Account: (i.e., checking, savings) _____

Total Designation: _____

Payment Amount:
(Amount based on your plan selection on page 2)

EPO: $_____ HSP: $_____

*Payment every: Month ☐ Three Months ☐ Six Months ☐ Annual One-Time Only ☐

Automatic Debit Date:
(Once per month,1st weekday of the month: non-holiday / non-weekend.) _____

First Debit Date: _____

Please be aware that the school district will pass on all imposed bank fees for a debit not honored due to non-sufficient funds.

By providing your information and signing this form, you are authorizing Lake Havasu Unified School District #1 to automatically debit your account for the LHUSD #1 Retiree Insurance Premium as outlined above:

Signature: _____ **Date:** _____

Print Name: _____

FOR OFFICIAL USE ONLY: ***Date processed:*** _____ ***Processed by:*** _____

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2200 Havasupai Blvd, Building C,
Lake Havasu City, AZ 86403
Phone 928-505-6930 payroll@lhusd.org

2023-24 RETIREE INSURANCE PREMIUM RATES

AUTOMATIC PAYMENT PLAN FORM

Name: (Please Print) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Phone: _____ Email: _____

		EPO PLAN					Select Your Monthly Premium
		Annual Cost of Insurance	70% District Contribution	District/ASRS Contribution	Retiree Annual Premium	Retiree Monthly Premium	
Retiree Only	Medical	$13,306.20	$8,887.79	$0.00	$4,418.41	$368.20	0.00
	Dental/Vision	$594.84	$416.39	$0.00	$178.45	$14.87	0.00
	Life	$48.00	$33.60	$0.00	$14.40	$1.20	0.00
	Combined	$13,949.04	$9,337.78	$0.00	**$4,611.26**	**$384.27**	$ 0.00
Retiree + Spouse	Medical	$26,425.08	$8,887.79	$0.00	$17,537.29	$1,461.44	0.00
	Dental/Vision	$1,168.92	$416.39	$0.00	$752.53	$62.71	0.00
	Life	$48.00	$33.60	$0.00	$14.40	$1.20	0.00
	Combined	$27,642.00	$9,337.78	$0.00	**$18,304.22**	**$1,525.35**	$ 0.00

		HSP (HDHP) PLAN					Select Your Monthly Premium
		Annual Cost of Insurance	70% District Contribution	District/ASRS Contribution	Retiree Annual Premium	Retiree Monthly Premium	
Retiree Only	Medical	$12,696.84	$8,887.79	$0.00	$3,809.05	$317.42	0.00
	Dental/Vision	$594.84	$416.39	$0.00	$178.45	$14.87	0.00
	Life	$48.00	$33.60	$0.00	$14.40	$1.20	0.00
	Combined	$13,339.68	$9,337.78	$0.00	**$4,001.90**	**$333.49**	$ 0.00
Retiree + Spouse	Medical	$25,194.84	$8,887.79	$0.00	$16,307.05	$1,358.92	0.00
	Dental/Vision	$1,168.92	$416.39	$0.00	$752.53	$62.71	0.00
	Life	$48.00	$33.60	$0.00	$14.40	$1.20	0.00
	Combined	$26,411.76	$9,337.78	$0.00	**$17,073.98**	**$1,422.83**	$ 0.00

I authorize LHUSD #1 to deduct from my account the above designation for the amount I have chosen. I understand **I must request this deduction on an annual basis.**

Please Return Signed Dated Form to Payroll, at the LHUSD #1 District Office.

Signature: _____ **Date:** _____

FOR OFFICIAL USE ONLY:
Deduction will begin on _____ Contribution rate is $ _____ Insurance Plan _____