benefitexpress

AUTOMATIC PAYMENT (ACH) REQUEST FORM

PLEASE READ:

1. **To be eligible for recurring ACH, you may be required to be paid through the current coverage month and/or your next/first premium due must be for a future month. If you are attempting to use ACH for your first premium due, please contact your administrator to ensure eligibility. This form only applies to monthly billing period. Additional options are available online.**
2. Complete **Section 1** -- Participant Information.
3. Attach a voided check (or photocopy). We are not able to accept deposit slips.
4. If you do not supply a voided check, complete **Section 2**.
5. Complete **Section 3** and fax the form along with your voided check to us at **855-343-8181** or mail to the address below.
6. When adding your ACH, please note we need to receive notification at least 10 days prior to the 1st of the month.
7. When canceling or changing your ACH, please note we need to receive notification at least 15 days prior to the 1st of the month of your request. If your request is **received after** this timeframe, we may continue to process your ACH as normal.
8. We are not able to process incomplete forms.

SECTION 1 - PARTICIPANT INFORMATION

☐ **ADD** AUTHORIZATION	☐ **CANCEL** AUTHORIZATION Effective:	☐ **CHANGE** AUTHORIZATION Effective:
Full Name: (please print clearly)		**Last 4** of **SSN:**
Phone Number:	**Member ID Number:**	

SECTION 2 - BANK ACCOUNT INFORMATION

Bank Name:	**Account Type** (check one) ☐ CHECKING ☐ SAVINGS
Routing Number:	
Account Number:	

1200

PAY TO THE ORDER OF $

DOLLARS

FOR

⑆122105278⑆ 6724301068⑈ 1200⑈

Routing Number Account Number Check Number

SECTION 3 - AUTHORIZATION SIGNATURE

Authorized Account Holder Signature	**Date**

I authorize **benefitexpress** ("Company") to initiate a debit from my checking or savings account for my recurring scheduled payment via ACH. My recurring scheduled payment will be debited on the 1st or the 5th of the month (or the following business day). I understand that the amount of my scheduled payment may change in the future if, for example, my insurance premium changes or my number of dependents changes, and I authorize Company to initiate debits in amounts equal to the new required premium payment plus additional service fees, if any. I further authorize Company to initiate a one-time debit for any amounts that are unpaid from previous billing periods at the time that this authorization takes effect. I understand that I can access information about the amount of my recurring scheduled payment and any amounts that are unpaid from previous billing periods at any time via Company's website and that I will receive notification of changes in premium payments. This authorization is to remain in full force and effective until Company has received written notification from me of its termination in such time and manner as to afford Company a reasonable opportunity to act on it. I understand that automatic debits will automatically cease if (a) my coverage ends, (b) my coverage is terminated, (c) my automatic debit rejects for any reason, or (d) there is a retroactive change in my premium payment that results in underpaid or unpaid amounts from previous billing periods.

Return This Form & Check To: **benefitexpress** **ACH Processing Department** **PO Box 2798** **Omaha, NE 68103-2798** **FAX (855) 343-8181**	**All Other Questions & Support Issues:** **benefitexpress** **PO Box 2798** **Omaha, NE 68103** **(877)837-5017**
Date Rec'd **Date Processed**	**Processor** **V&V**