Flexible Benefit Administrators, Inc.

AUTOMATIC PAYMENT (ACH) REQUEST FORM

PLEASE READ:

1. **To be eligible for COBRA ACH, you must be fully enrolled and paid to a current status. For non-COBRA billing, you must be paid through the current coverage month. Please note, ACH is only available for monthly billing periods.**
2. Complete **Section 1** -- Participant Information.
3. Attach a voided check (or photocopy). We are not able to accept deposit slips; they do not always show the required information.
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 will 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:

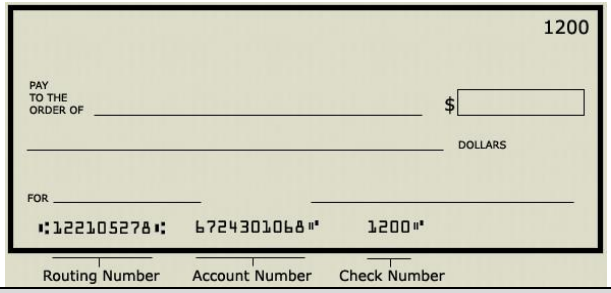
Your Full Name (please print clearly)	**Your Social Security Number** ☐☐☐ - ☐☐ - ☐☐☐☐

SECTION 2 - BANK ACCOUNT INFORMATION

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

Routing Number:

Account Number:



SECTION 3 - AUTHORIZATION SIGNATURE

Authorized Account Holder Signature	**Date**

I authorize **Flexible Benefit Administrators, Inc.** ("Company") to initiate a debit from my checking or savings account for my recurring scheduled payment via ACH. If the required payment changes for any reason, this authorization will be automatically amended to authorize the debit of the amount equal to the new required premium payment plus any additional service fees, if any.

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 my coverage ends, is terminated or my automatic debit rejects for insufficient funds.

I understand and agree to the terms outlined and authorize Company to make appropriate changes to my required premium deduction as necessary.

Return This Form & Check To:	**All Other Questions & Support Issues:**
Flexible Benefit Administrators, Inc. **ACH Processing Department** **PO Box 2468** **Omaha, NE 68103-2349** **FAX (855) 343-8181**	**Flexible Benefit Administrators, Inc.** **PO Box 2070** **Virginia Beach, VA 23450** **(800) 437-3539**
Date Rec'd **Date Processed**	**Processor** **V&V**