



Employee Benefits Corporation

Direct Payment Authorization Form

Return this form and voided check to:

Mail to: **Employee Benefits Corporation**
ACH Processing Department
PO Box 2420, Omaha NE 68103-2420
Fax: **(855) 343-8181**

All other questions and support issues:

Mail to: **Employee Benefits Corporation**
PO Box 44347, Madison WI 53744-4347
Phone Support: **800 346 2126** | 608 831 8445
Email Support: **participantservices@ebcflex.com**

To enroll in Direct Payment, please read the instructions on the next page, fill in the information requested below and return the completed form to Employee Benefits Corporation. **BE SURE TO THOROUGHLY READ THE INSTRUCTIONS ON THE NEXT PAGE.** When mailing your Direct Payment Authorization form, please attach a copy of a voided check.

Continuant Information

Last 4 Digits of Social Security Number (Required)

Last Name	Suffix	First Name	MI
Mailing Address	Apt. No.	City	State Zip Code
Date of Birth (mm-dd-yyyy)	E-mail Address (we do not share your e-mail address)	Telephone (000-000-0000)	

Account Holder Information (if different)

Last Name	Suffix	First Name	MI
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Payment Type

COBRASecure Premium Payments
 Retiree or Premium Billing Payments
 Both

Financial Institution Information

Name of Financial Institution	Branch
Financial Institution Address	City State Zip Code
Account Name	Account Number Routing Number
Financial Account Type	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Transaction Type	<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Cancel

Depositor Certification

I certify that I have read and understand the Auto-Debit instructions provided. In signing this form, I authorize my insurance premiums to be automatically debited from the account designated above.

X _____
Signature Date (mm-dd-yyyy)

Print Name Title

Joint Account Holders Certification (if applicable)

X _____
Signature Date (mm-dd-yyyy)

Print Name Title

Instructions

Participants in Employee Benefits Corporation's COBRASecure Administration or Retiree/Premium Billing Services have the option to have their monthly premium directly debited from their personal checking or savings account. It is an optional convenience called Auto-Debit.

Conditions of Participation include:

- Your financial institution must be a member of an Automated Clearing House (ACH).
- If you decide to enroll in Direct Payment, you must complete the authorization form.
- If your account is a joint account, both parties holding the joint account must complete the authorization form.
- If you wish to cancel your participation in Direct Payment you must complete another authorization form and mark "Cancel" under Transaction Type. The agreement represented by this authorization will remain in effect until you cancel it.
Your cancellation request must be received no later than the 15th of the month prior.
- It is your responsibility to notify us immediately of any changes in your financial institution (i.e. change of account number, closure of account, etc.) To notify us of the change, use the Direct Payment Authorization Form. Mark the Change box in the Type of Transaction entry on the first page of the form. We will process these changes immediately upon receipt of the form. Since changes of this type usually take 2-3 weeks to complete, please plan accordingly.
- Incomplete forms will not be processed.

- Your electronic debit will be made directly from your account on the 1st of each month (or the first business day thereafter) if you are a COBRA continuant or the 5th business day of the month if you are a retiree or premium billing continuant. If this transfer cannot be completed, Employee Benefits Corporation will notify you. Pending resolution of the issue, you will continue to be responsible to submit payment directly for each subsequent monthly payment. Reinstatement in Direct Payment will be determined on a case-by-case basis and you will be notified.
- Payments must be current and ACH information must be received by Employee Benefits Corporation no later than the 20th of the month prior to the start of Direct Payment.
- Your financial institution may cancel this agreement. In such cases, you will be required to submit manual payments.
- This Direct Payment Authorization will remain in effect throughout any rate changes, until you notify us to terminate or until coverage ends. If there is a shortage on a monthly premium due to a rate change, it will be your responsibility to pay any shortage via check to bring your account to current.