LIFETIME BENEFIT SOLUTIONS, INC.
AUTOMATIC PAYMENT (ACH) REQUEST FORM

PLEASE READ:

1. **To be eligible for ACH, you must be fully enrolled and current with payments before ACH will begin.**
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 first of the month.**
7. **When canceling or changing your ACH, please note we need to receive notification at least fifteen days prior to the first 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.**

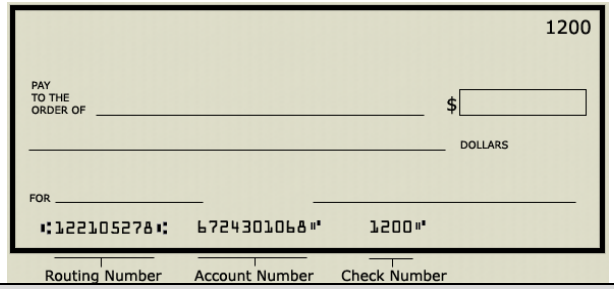
SECTION 1 - PARTICIPANT INFORMATION

☐ADD AUTHORIZATION Effective:	☐CANCEL AUTHORIZATION Effective:	☐ CHANGE AUTHORIZATION Effective:

Your Full Name (please print clearly)	☐ Retiree Medical Billing ☐ COBRA
Phone Number:	Member ID Number (Located on Invoice):

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 Lifetime Benefit Solutions, 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: Lifetime Benefit Solutions, Inc. ACH Processing Department PO Box 2979 Omaha, NE 68103-2979 FAX 855.343.8181	All Other Questions & Support Issues: Lifetime Benefit Solutions, Inc. COBRA and Premium Billing Administrative Services PO BOX 332 Liverpool, NY 13088 800.493.0318 (TTY/TTD: 800.662.1220)
Date Rec'd Date Processed	Processor V&V

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