AUTOMATIC PAYMENT (ACH) REQUEST FORM
MONTHLY DEBIT AUTHORIZATION:

Attach a voided check (or photocopy).
We are not able to process incomplete forms.
Questions & Support: (855) 483-3539

☐ Add
☐ Cancel
☐ Change

Please note: All payments may be direct debited via ACH. ACH debits are processed around the 10th of the month. If you have a premium due for a past month, the amount will be added onto the ACH debit for the current month.

SECTION1 – PARTICIPANT INFORMATION

Please print clearly and complete all fields.

PARTICIPANT FULL NAME:

PLAN SPONSOR (EMPLOYER):

SOCIAL SECURITY NUMBER: ☐☐☐ - ☐☐ - ☐☐☐☐

PHONE NUMBER: ☐☐☐ - ☐☐☐ - ☐☐☐☐

SECTION 2 – BANK ACCOUNT INFORMATION

BANK NAME:

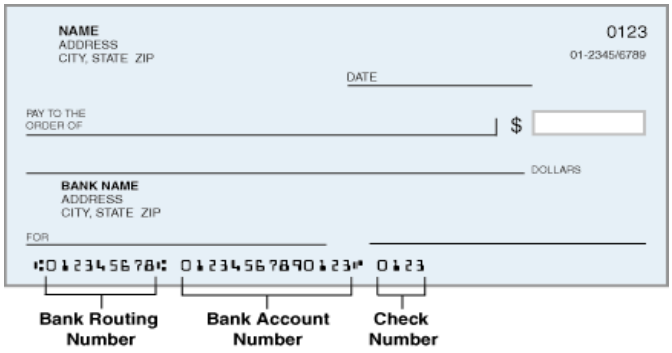
ACCOUNT TYPE *(check one)*
☐ **CHECKING** ☐ **SAVINGS**

ROUTING NUMBER: ☐☐☐☐☐☐☐☐☐

ACCOUNT NUMBER: ☐☐☐☐☐☐☐☐☐☐☐☐

Sample Check & ACH Processing Detail

Use sample check to locate your Routing and Account Numbers:



When adding or changing ACH we need to receive a completed request form by the 5th of the month to process ACH as normal. If your request to cancel is received after this timeframe, we will continue to process ACH as normal for current month and adjust ACH detail for payments due the 1st of the month following submission of the request. Benefit Strategies will make every attempt to contact you of an ACH failure, but it will be your responsibility to monitor payments to assure payment confirmation. Please allow 3-5 business days for processing of this request. ACH Payments may also be started, stopped, and changed through the secure member portal. Visit www.premiumbilling.benstrat.com or call 855-483-3539 for details.

SECTION 3 – AUTORIZATION SIGNATURE

ACCOUNT HOLDER SIGNATURE:

DATE:

I authorize **Benefit Strategies, LLC** ("Company") to initiate debit entries 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 will remain in full force and effective until Company has received written notification from me of its termination in a 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 Benefit Strategies, LLC to make appropriate changes to my required premium deduction as necessary.

Return This Form & Check To:
Mail: Benefit Strategies, LLC
P. O. Box 3938
Manchester, NH 03105-3938
FAX: (603) 232-1854
SCAN & Email: hvdflex@benstrat.com

Want us to confirm other information on file while processing this request?
Make sure we have the most up to date:
Participant Email :
Participant Address:
Anything else we should know? Notes:

Harvard University Direct Bill/Retiree & COBRA