# Automatic Payment (ACH) Request Form

**PLEASE READ:**

- **To be eligible for recurring ACH, you must be paid through the current coverage month and your next premium due must be for a future month. In the event you are attempting use ACH for your first premium due, please contact your administrator to ensure eligibility. Please note, ACH is only available for monthly billing periods.**
- Complete **Section 1** -- Participant Information.
- Attach a voided check (or photocopy). We are not able to accept deposit slips.
- If you do not supply a voided check, complete **Section 2**.
- Complete **Section 3** and fax the form along with your voided check to us at **855.343.8181** or mail to the address below.
- When adding your ACH, please note we need to receive notification at least 10 days prior to the 1st of the month.
- 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.
- We are not able to process incomplete forms.

## SECTION 1 - PARTICIPANT INFORMATION

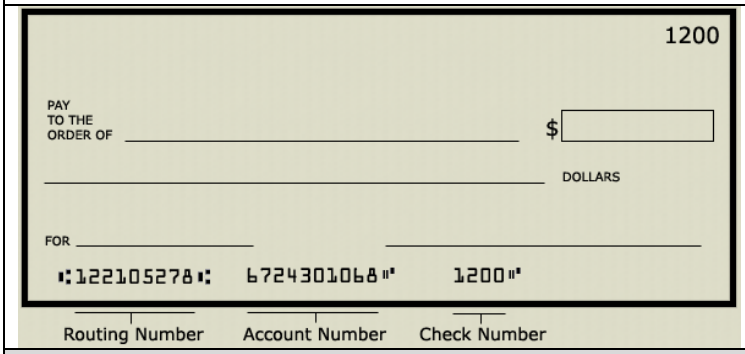
| **ADD** AUTHORIZATION | **CANCEL** AUTHORIZATION<br>Effective: | **CHANGE** AUTHORIZATION<br>Effective: |
|---|---|---|
| **Full Name:** (please print clearly) | | **Last 4** of **SSN:** |
| **Phone Number:** | | **Member ID Number:** |

## SECTION 2 - BANK ACCOUNT INFORMATION

| **Bank Name:** | **Account Type** (check one)<br>CHECKING ☐ SAVINGS ☐ |
|---|---|

**Routing Number:**

**Account Number:**




## SECTION 3 - AUTHORIZATION SIGNATURE

| **Authorized Account Holder Signature** | **Date** |
|---|---|

I authorize Ameriflex 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 understand that I can access information about the amount of my recurring scheduled payment at any time 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 my coverage ends, is terminated or my automatic debit rejects for any reason.

| **Return This Form & Check To:** | **All Other Questions & Support Issues:** |
|---|---|
| **Ameriflex ACH Processing Department**<br>**PO Box 2077**<br>**Omaha, NE 68103-2077**<br>**FAX (855) 343-8181** | **Ameriflex COBRA/Direct Bill**<br>**2508 Highlander Way**<br>**Carrolton, TX 75006** |
| **Date Rec'd**<br>**Date Processed** | **Processor**<br>**V&V** |