

Financial Network Group Health Plan

AUTHORIZATION AGREEMENT Direct Withdrawals /Direct Deposits (ACH Debits/Credits)

I (we) hereby authorize FINANCIAL NETWORK GROUP HEALTH PLAN, hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any credit entries in error to my (our) Checking or Savings account (select one) at the financial institution, hereinafter called BANK, and to credit the same to such account.

BANK NAME	_____	AMOUNT	_____
CITY, STATE	_____		
ROUTING NUMBER	_____	ACCOUNT NO.	_____

Please remember in addition to your monthly premium there is an annual enrollment fee of \$475/participant as well as a monthly participant administration fee.

***Any NSF will result in an additional \$50 fee. ***

****Attach a voided check for verification****

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Printed Name

Office Location and Name

Signature (typed name serves as signature)

Date

Effective Plan Date:

Click Here to Submit Form: