FBMC
BENEFITS MANAGEMENT

# Direct Debit (ACH) Authorization Form
# For Monthly Premium Billing Payments

**Participant Information** ☐ New ACH ☐ Change ACH ☐ Cancel ACH

Former Employer Name: _____

Participant Name (please print): _____

Dependent Name (please print): _____

Street Address _____

City, State, Zip _____ Telephone #:_____

Name of Financial Institution: _____

Account Type: ☐ Checking ☐ Savings ☐ Other

Routing Number ____ ____ ____ ____ ____ ____ ____ ____ ____

Account Number _____

Routing number is the first nine digits reflected in the bottom left corner of your check. Please attach a voided check of the account number that the direct debit will be drawn against. If you have elected Savings or Other, please provide a verification letter for that account.

## Authorization

I am an authorized signer on the above-referenced account. I hereby authorize FBMC Benefits Management, Inc. ("FBMC") to direct debit that account on the 10th day of each month all premium payments due for myself and my eligible dependents. Should the payment date fall on a weekend or holiday, the debit will be deducted on the next business day. If funds in your designated account are insufficient to cover the premium payment required, FBMC will require you to remit a check for the full premium amount in order to prevent termination of coverage. If there's an outstanding balance on the account, FBMC will withdraw the past-due amount in addition to the monthly premiums.

This authorization remains in effect until FBMC receives my written notification to rescind this authorization and is given reasonable time to act on my instructions. I also understand that until such time that the financial institution has finalized the direct debit process, I must continue to send my monthly premium payments via check or money order directly to FBMC to avoid any interruption or cancellation of coverage.

I acknowledge that the origination of ACH transactions to my account must comply with provisions of U.S. law and agree not to dispute this recurring billing with my financial institution so long as the transactions correspond to the terms indicated in this authorization form.

Participant Signature:_____ Date: _____

Dependent Signature: _____ Date: _____

**Return form to:**
**FBMC Benefits Management, Inc.**
**Attn: Mail Slot 32**
**PO Box 10789**
**Tallahassee, FL 32302**
Fax: 866-836-9943, Email: JHSretiree@fbmc.com

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## Attach Voided Check

(Note: if a voided check from your checking account or a verification letter for a savings or other account is not attached, this form will be returned to you and not processed.)

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**PO Box 10789**
**Attn: Mail Slot 32**
**Tallahassee, FL 32302**
Fax: 866-836-9943, Email: JHSretiree@fbmc.com