DISCOVERY BENEFITS, INC.

AUTOMATIC PAYMENT (ACH) REQUEST FORM

PLEASE READ:

1. **FOR ACH FOR YOUR FIRST MONTH OF COVERAGE**, a completed form must be received at least 10 days prior to the 1st of the month in which coverage starts.
2. **FOR ACH AFTER YOUR COVERAGE HAS ALREADY STARTED**, a completed form must be received at least 10 days prior to the 1st of the month in which you want ACH to begin and the premium payment for the previous month must be received at least 7 days prior to the 1st of the month in which you want ACH to begin.
3. Confirm the timing of when your ACH payments are to begin before ceasing payment through any other method to ensure you remain current in your premium payments.
4. ACH is only available for monthly billing periods. If your premium amount is increased due to mid-month coverage changes, you are responsible for paying the increased amount for that month within the normal grace period. You are also responsible for monitoring whether payment for the following month is successfully withdrawn and posted to your account.
5. Complete Sections 1, 2 (if you do not supply a voided check), and 3. Fax the completed form with a copy of your voided check to 855-343-8181 or mail to the address on the next page.
6. To terminate or change ACH, a completed form must be received at least 15 days prior to the 1st of the month. If your request is received after this timeframe, the effective date of the cancellation or change may be delayed by one month.

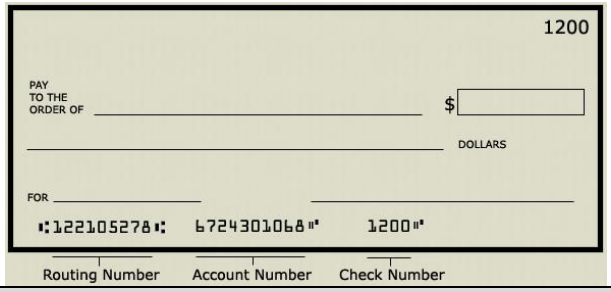
SECTION 1 - PARTICIPANT INFORMATION

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

Your Full Name (please print clearly)	**Your Social Security Number** ☐☐☐ - ☐☐ - ☐☐☐☐
Phone Number:	**Member ID Number:**

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 **Discovery Benefits, Inc**. ("Company") to initiate a debit from my checking or savings account for my recurring scheduled payment via ACH and, if necessary, to initiate adjustments for any transaction credited/debited in error, to the account indicated above. 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. I agree to comply with U.S. laws and NACHA Rules with respect to ACH transactions to my account. 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:	All Other Questions & Support Issues:
DISCOVERY BENEFITS, INC. **ACH Processing Department** **PO Box 2079** **Omaha, NE 68103-2079** **FAX (855) 343-8181**	**DISCOVERY BENEFITS, INC.** **PO BOX 2079** **Omaha NE 68103-2079** **(866) 451-3399**
Date Rec'd **Date Processed**	**Processor** **V&V**