DIRECT PAYMENT AUTHORIZATION FORM

The Pennsylvania Employees Benefit Trust Fund (PEBTF) is pleased to offer The Direct Payment Plan. You now can have your health insurance payments deducted automatically from your checking account.

Here's how the plan works:
You authorize regularly scheduled payments to be made from your checking account. You will receive a confirmation letter showing when your payments will be deducted from your specified account. Please make sure that you continue to submit your payments either by check or credit card until that time. Your proof of payment will appear on your statement. The authority you give to charge your account will remain in effect until you notify us in writing to terminate the authorization.

To take advantage of this service, complete the authorization form below and return it to:

PEBTF
ATTN: Accounts Receivable
150 S 43RD Street
Suite 1
Harrisburg, PA 17111

All you need to do is:

1. Fill in your name, Member ID #, financial institution name, location, sign, and date
2. Attach a **voided check** for verification of all financial institution information.
3. Fill in your account number and routing number.

Please complete the information below and sign the form.

YOUR NAME ____

CUSTOMER NUMBER (Member ID #) ________________________________

By signing below, you authorize the **Pennsylvania Employees Benefit Trust Fund** to initiate electronic debit entries to the account specified below for payment of your health insurance premium. You understand that you may terminate this authorization by notifying us in writing at the address above by the 15th of the month prior to the next payment date. You understand and acknowledge that electronic debit entries are subject to applicable laws, regulations, and/or network rules. To the extent that any electronic debit entry is returned unpaid, you authorize us to re-initiate the entry as permitted by applicable laws and rules. You understand that your financial institution may assess a fee in the event you do not have sufficient funds in your account to pay an electronic debit entry and that we shall have no liability to you for any such fee.

In addition, you acknowledge that if there is any past due balance on your billing account at the time of your first withdraw, you authorize a one-time increased withdraw amount to satisfy the balance due in full. All remaining withdraws will be for the monthly premium rate.

Financial Institution Name:	Financial Institution City And State:
Account Number:	Routing Number:

SIGNATURE ______________________________________ DATE ________________

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