



Flexible Benefits Plans

www.flexiben.com

PRE-AUTHORIZED ACH DEBIT FORM

POLICY NUMBER: _____ (New members should leave this field blank)

Authorization to Honor Debits by Flexible Benefits Plans, Inc.

Please sign the authorization in the designated area in accordance with your signature(s) on file at your financial institution. Please notify us if you change your address or wish us to charge a different account in the future.

I hereby authorize this financial institution to pay and charge my account for electronic debits drawn on my account by Flexible Benefits Plans, Inc. to its own order. This authorization will remain in effect until revoked by me, in writing, and until you receive such notice. I agree that you shall be fully protected in honoring any such electronic debit.

I agree that your treatment of each such electronic debit, and your rights to respect it, shall be the same as if it were signed by me personally. I further agree that if any such electronic debit be dishonored, whether with or without cause, you shall be under no liability **whatsoever even though such dishonor results in the lapse of insurance.**

DEPOSITOR(S)	YOUR BANK
_____ Depositor Name listed on the account	_____ Bank Name
_____ Joint Depositor (if any)	_____ Bank Address
_____ Signature of Depositor	_____ City State Zip Code
_____ Signature of Joint Depositor	_____ Bank Phone
_____ Email Address (Required)	_____ Checking Account Number you wish us to debit

Debits are transacted on the 1st business day of each month. All changes to ACH must be submitted to our office by the 25th of the month in order to guarantee your changes.

Please attach a voided check (no deposit slips, please)