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 $500/participant as well as a monthly participant administration fee.

***Any NSF will result in an additional $55 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**

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Effective Plan Date:

Please fax to 866 - 817 - 2969 or save the form and add it as an attachment to email that come up by clicking the box

09/27/2024