

PAY TYPE FORM

Name: _____ Social Security No: _____

Group/Former Employer: _____

CHOOSE ONE OPTION

Option 1: **Pension Deduction**

I hereby authorize BenefitHelp Solutions to make the necessary deduction from my monthly benefits to cover the premium for my group medical and/or dental plan. *In order to choose this option, my monthly pension amount must be greater than the amount of the premium for my group medical and/or dental plan. If my premiums exceed my pension at any date in the future, BenefitHelp Solutions will automatically change me to the self-pay option.*

Signature

Date

Option 2: **Electronic Fund Transfer (EFT)**

Checking

Savings

BANK NAME: _____ BRANCH _____

BANK ADDRESS: _____

BANK ACCOUNT NO: _____

This authority is to remain in full force and effect until BenefitHelp Solutions and my bank have received written notification from me of its termination in such time and in such manner as to afford BenefitHelp Solutions and my bank a reasonable opportunity to act on it. I have the right to stop payment of a debit entry by notification to my bank in such time as to afford my bank a right to have the amount of an erroneous debit immediately credited to my account by my bank, provided I send written notice of such error to the bank within 15 days following the issuance of the account statement or 45 days after posting, whichever occurs first.

Signature

Date

****Please attach a voided check to verify account numbers.***

Option 3: **Monthly Invoice (Self Pay)**

If payments are not received by the first, your account will be in arrears and you may receive termination warning from the carrier.

Signature

Date