

PAY TYPE FORM

Name: _____ Social Security No: _____
(Name of Applicant) (SSN of Applicant)

Name: _____ Social Security No: _____
(Name of Pension Account Holder) (SSN of Pension Account Holder)

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 of Applicant _____ Date _____ Signature of Pension Account Holder _____ Date _____

Option 2: Electronic Fund Transfer (EFT)*

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 checking/savings account numbers.***

Option 3: Monthly Invoice (Self Pay)

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

Signature _____ Date _____

Mail: P.O. Box 40548, Portland OR 97240-0548 Phone: 855.289.6315 or 503.412.4242 Fax: 888.393.2943