Retiree EFT Authorization Form

Set-up auto-pay so that your premium amount will automatically be withdrawn from your bank account via Electronic Funds Transfer (EFT/ACH) on a monthly basis and avoid the risk of your coverage lapsing. This convenient payment option ensures timely receipt of your monthly premium payments.

Return the completed authorization form below to establish automatic monthly premium payments.

If you have any questions in completing the form, please contact the Retiree Service Center at Monday through Friday.

TO ACTIVATE:

1) Sign and date the Authorization Form below.
2) Return the completed form along with a voided check
   MAIL TO: Retiree Service Center/Auto-Pay sign up
   PO Box 14464
   Des Moines, IA 50306-3464
3) You will receive notification once auto-pay set up has been completed.

Data to be collected (all fields are required unless specifically noted):

Certificate #: ___________________________

Type of Account (Check One)

☐ Personal Checking ☐ Personal Savings ☐ Business Checking

Enter routing # & account # only for savings account; for checking account use box below to initial.

Bank Routing Number: ____________________________

Bank Account Number: ____________________________

Initial here to use the routing and bank account # from the enclosed voided check as the account to debit.

Bank Account Name: ___________________________ **(if different than Company Name or your name)**

Company Name: ____________________________ **(Required for Business Checking)**

First Name*: _________________________ **Last Name*:** ______________________________

Street Address: ____

Address (apt. #): ____

City: ____________________________________ **State:** __________ **Zip Code:** ___________

Phone Number: _________________________

Email Address: ____

*Not required for Business Checking.

SIGN & DATE: As of the date below I authorize Mercer Health & Benefits Administration LLC to establish a recurring automatic bill payment to pay my insurance premiums each month to be processed as electronic funds transfers (EFT) or drafts drawn from my bank account as indicated below. I also authorize my financial institution to charge my account accordingly. I understand that my premium amount is based on coverage selected and that if my premium changes I will be notified, and my payment will be adjusted accordingly. I understand that my payment will process around the 5th business day of the month. I understand that this authorization will remain in full force and effect until I notify you that I wish to revoke it by calling the Retiree Service Center and allow you reasonable opportunity to act on my notice. I agree to notify Mercer Health & Benefits Administration LLC should my account information change.

Signature: ____ **Date:** __________________________