PLANSOURCE
One Source. Many Benefits.

AUTOMATIC PAYMENT (ACH) REQUEST FORM

Instructions:

1. Complete **Section 1** – Participant Information.
2. Please attach a voided check (or a photocopy). Deposit slips cannot be accepted.
3. If you do not provide a voided check, please complete **Section 2** instead.
4. After completing the required sections, fill out **Section 3** and fax the form, along with your voided check, to 855-343-8181, or mail the form to the address provided below.
5. The Member ID Number is located at the bottom left corner of this form or on any payment coupon issued by PlanSource.
6. Incomplete forms cannot be processed.

Important Timing Notes:

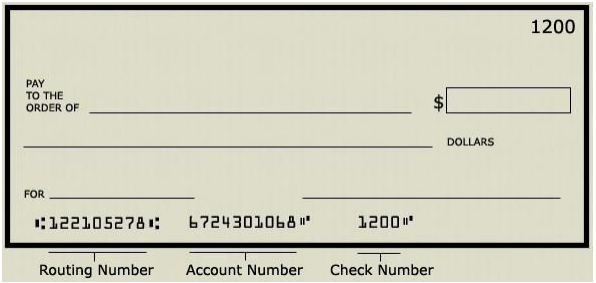
1. The ACH form must be received at least 10 days prior to the 1st of the month or the system with automatically true up any balance due the following month
2. When canceling or changing your ACH, notification must be received at least 15 days prior to the 1st of the month for the requested change to take effect. Requests received after this window may result in the ACH continuing to process.

SECTION 1 - PARTICIPANT INFORMATION

☐ **ADD** AUTHORIZATION	☐ **CANCEL** AUTHORIZATION Effective:	☐ **CHANGE** AUTHORIZATION Effective:
Full Name: (please print clearly)		**Last 4** of **SSN:**
Phone Number:	**Member ID Number:**	

SECTION 2 - BANK ACCOUNT INFORMATION

Bank Name:	**Account Type** (check one) ☐ CHECKING ☐ SAVINGS
Routing Number:	
Account Number:	



SECTION 3 - AUTHORIZATION SIGNATURE

Authorized Account Holder Signature	**Date**

I authorize WEX Health, Inc., as agent of PlanSource ("Company") to initiate a debit from my checking or savings account for my recurring scheduled payment via ACH. My recurring scheduled payment will be debited on the 1st or the 5th of the month (or the following business day). I understand that the amount of my scheduled payment may change in the future if, for example, my insurance premium changes or my number of dependents changes, and I authorize Company to initiate debits in amounts equal to the new required premium payment plus additional service fees, if any. I understand that I can access information about the amount of my recurring scheduled payment at any time and that I will receive notification of changes in premium payments. This authorization is to remain in full force and effective until Company has received written notification from me of its termination in such time and manner as to afford Company a reasonable opportunity to act on it. I understand that automatic debits will automatically cease if my coverage ends, is terminated or my automatic debit rejects for any reason.

Return This Form & Check To:	**All Other Questions & Support Issues:**
PlanSource **ACH Processing Dept** **PO Box 3850** **Omaha, NE 68103-0850** **FAX (855) 343-8181**	**(888)-266-1732**
Date Rec'd **Date Processed**	**Processor** **V&V**