



Insurance • Payroll • HR Solutions

Personal. Proactive. Powerful.

ACH Payment Set-Up/Change Form

Company/Account Name: _____

Address: _____

Email: _____

Opt-In for e-invoicing? (circle one) YES NO

Please indicate which accounts are to be updated:

- Benefit Premium* HRA/FSA Claim Reimbursement**

Bank Information

Bank Name: _____

Bank ABA (Routing) Number: _____

Account Number: _____

Account Type: (circle one) Checking Savings

ACH Effective Date: Month: _____ Year: _____

Please attach a voided check from the above account

*I authorize Bene-Care, Inc. to debit the above account for premium payment on the due date of each month that coverage is in effect. **PLEASE NOTE: Because insurance must be paid in advance, debits will occur on approximately the 27th of the month PRIOR TO the month of coverage.**

**I authorize Bene-Care, Inc. to debit the above account for HRA/FSA claim reimbursements.

Authorized Signature	Title	Date
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Print Name	Title	Date
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