AGREEMENT for PRE-AUTHORIZED PREMIUM PAYMENTS
(Auto Pay)

I (we) authorize Employee Benefit Plan Administration**,** hereafter called **EBPA**, to withdraw (debit) the amount of my (our) monthly COBRA/Retiree or Direct Bill health premium payment from my (our) checking or savings account indicated below and the financial institution (e.g., bank, credit union, etc.) named below, hereafter called **FINANCIAL INSTITUTION**, to debit the same to such account. Debits will occur the first business day of each month.

Employer Name COLUMBIA UNIVERSITY

Your Name _____ **Last 4 Digits of SSN: XXX-XX-** ___ ___ ___ ___

Address_____ **City, State, ZIP**_____

Please withdraw funds from the account indicated below beginning _____/____/_____.

☐ Checking account (attach a voided check to this form)

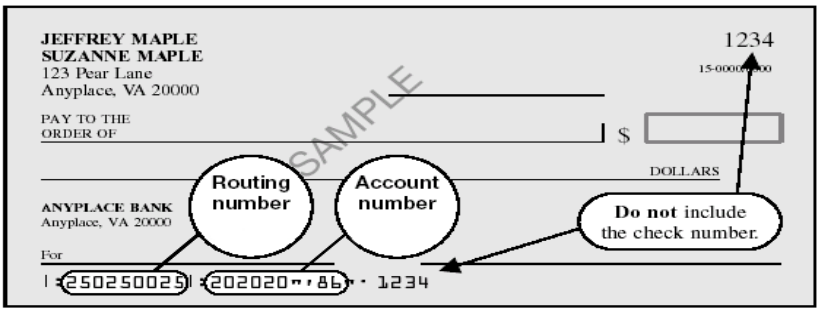
☐ Savings account
(Obtain the 9 digit ABA routing number from your bank)

Financial Institution Name: _____

Local Branch City, State, ZIP:_____

Financial Institution Routing # (see sample check below)_____

Account # (see sample check below) _____



Note. The routing and account numbers may be in different places on your check.

This authorization is to remain in full force and effect until **EBPA** has received written notification from me (us) of its termination in such time and in such manner as to afford EBPA and Financial Institution a reasonable opportunity to act on it.

Signature_____ Phone Number: (_____)_____

Signature_____ Phone Number: (_____)_____
(Joint Account Holder)

Please mail or fax this completed Agreement form along with a voided check (if applicable) to:

EBPA
37 Industrial Drive, Ste. E Exeter, NH 03833
Fax# 603-773-4410. If you have questions, call EBPA at 1-888-232-3203