ebpa
a Cobalt company

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. **Please note that your bank statement will have the description "DFS Inc FLEX Plan." Any past due premiums will be processed upon receipt of this form.** Ongoing debits will occur the first business day of each month.

Employer Name _____

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

Address_____ **City, State, ZIP**_____

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

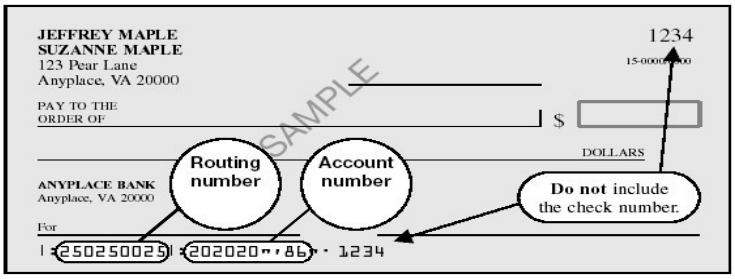
☐ Savings account
(Obtain the 9 digit ABA routing number from your bank)

Financial Institution Name: _____

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 this completed Agreement form along with a voided check (if using checking account) to:

EBPA CL# 218
PO Box 1387
Williston, VT 05495-1387

If you have questions, call EBPA at 1-888-232-3203