



## AUTOMATIC PAYMENT (ACH) REQUEST FORM

### PLEASE READ:

1. To be eligible for COBRA ACH, you must be fully enrolled and paid to current month billing status.
2. Complete **Section 1** -- Participant Information and **Section 2** -- Bank Account Information
3. Attach a voided check (or photocopy). We are not able to accept deposit slips; they do not always show the required information.
4. Complete **Section 3** and fax the form along with your voided check to us at **925-460-3929** or mail to the address below.
5. When adding your ACH, please note we need to receive notification at least 10 days prior to the 1<sup>st</sup> of the month.
6. When canceling or changing your ACH, please note we need to receive notification at least 15 days prior to the 1<sup>st</sup> of the month of your request. If your request is **received after** this timeframe, we will continue to process your ACH as normal.
7. We are not able to process incomplete forms.
8. A \$25 fee will be assessed for insufficient funds.

### Bank ACH Debit Date:

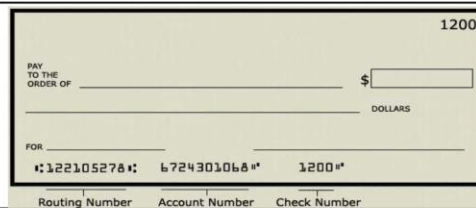
— COBRA Members ACH Debit Date: 1<sup>st</sup> of every month in which premium is due

### SECTION 1 - PARTICIPANT INFORMATION

<input type="checkbox"/> <b>ADD AUTHORIZATION</b>	<input type="checkbox"/> <b>CANCEL AUTHORIZATION</b> Effective: _____	<input type="checkbox"/> <b>CHANGE AUTHORIZATION</b> Effective: _____
<b>Your Full Name</b> (please print clearly)		<b>Your Social Security Number</b> □ □ □ - □ □ - □ □ □ □
<b>Phone Number:</b>		<b>Member ID Number:</b>

### SECTION 2 - BANK ACCOUNT INFORMATION

<b>Bank Name:</b>	<b>Account Type</b> (check one) <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS
<b>Routing Number:</b>	
<b>Account Number:</b>	



### SECTION 3 - AUTHORIZATION SIGNATURE

<b>Authorized Account Holder Signature</b>	<b>Date</b>
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I authorize **Workterra** ("Company") to initiate a debit from my checking or savings account for my recurring scheduled payment via ACH. If the required payment changes for any reason, this authorization will be automatically amended to authorize the debit of the amount equal to the new required premium payment plus any additional service fees, if any. 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 insufficient funds. I understand and agree to the terms outlined and authorize Company to make appropriate changes to my required premium deduction as necessary.

### Return This Form & Voided Check To:

**WORKTERRA**  
P.O. Box 850091  
Minneapolis, MN 55485-0091  
or via Fax: 925-460-3929

**Date Rec'd**  
**Date Processed**