PAY TYPE FORM

Name:_____Social Security No: _____

Group/Former Employer: _____

CHOOSE ONE OPTION

Option 1: ☐ Electronic Fund Transfer (EFT)*

BANK NAME:_____BRANCH _____

BANK ROUTING:_____

BANK ACCOUNT NO: _____

This authority is to remain in full force and effect until BenefitHelp Solutions and my bank have received written notification from me of its termination in such time and in such manner as to afford BenefitHelp Solutions and my bank a reasonable opportunity to act on it. I have the right to stop payment of a debit entry by notification to my bank in such time as to afford my bank a right to have the amount of an erroneous debit immediately credited to my account by my bank, provided I send written notice of such error to the bank within 15 days following the issuance of the account statement or 45 days after posting, whichever occurs first.

_____ _____

Signature Date

Please attach a voided check to verify checking/savings account numbers.

Option 2: ☐ Monthly Invoice (Self Pay)

If payments are not received by the first, your account will be in arrears and you may receive termination warning from the carrier.

_____ _____

Signature Date

Mail: P.O. Box 40548, Portland OR 97240-0548 Phone: 800.556-3137 or 503.765.3581 Fax: 888-393-2943

www.benefithelpsolutions.com