AUTOMATIC PAYMENT (ACH) REQUEST FORM

PLEASE READ:

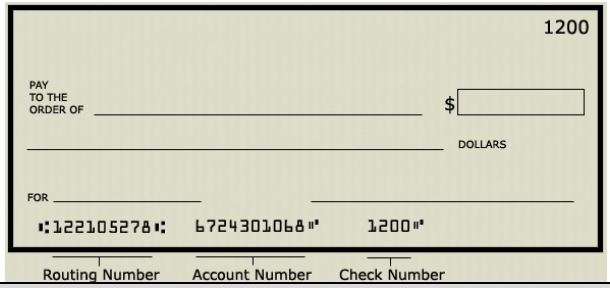
1. **To be eligible for a recurring automatic payment (ACH), you must be paid through the current coverage month and your next premium due must be for a future month. In the event you are attempting to use ACH for your first premium due, please contact MHS Member Services at 877-647-4848 to ensure eligibility. Please note, ACH is only available for monthly billing periods.**
2. Complete **Section 1** - Participant Information.
3. Please attach a voided check (or photocopy). We are not able to accept deposit slips.
4. If you do not supply a voided check, please complete **Section 2**.
5. Complete **Section 3** and fax the form along with your voided check to MHS ACH Processing at **833-455-2286** or mail to the address below.
6. When adding your ACH, please note we need to receive notification at least 10 days prior to the 1st of the month.
7. When canceling or changing your ACH, please note we need to receive notification at least 15 days prior to the 1st of the month of your request. If your request is **received after** this timeframe, we may continue to process your ACH as normal.
8. We are not able to process incomplete forms.

SECTION 1 - PARTICIPANT INFORMATION

☐ **ADD** AUTHORIZATION	☐ **CANCEL** AUTHORIZATION Effective:	☐ **CHANGE** AUTHORIZATION Effective:
Full Name: (please print clearly)		**Last 4** of **SSN:**
Phone Number:		**Member ID Number:**

SECTION 2 - BANK ACCOUNT INFORMATION

Bank Name:	**Account Type** (check one) ☐ CHECKING ☐ SAVINGS
Routing Number:	
Account Number:	



SECTION 3 - AUTHORIZATION SIGNATURE

Authorized Account Holder Signature	**Date**

I authorize MHS Power Account ("Company") to initiate a debit from my checking or savings account for my recurring scheduled payment via ACH. My recurring scheduled payment will be debited on the 5th of the month (or the following business day). I understand that the amount of my scheduled payment may change in the future if, for example, my insurance premium changes or my number of dependents changes, and I authorize Company to initiate debits in amounts equal to the new required premium payment plus additional service fees, if any. I understand that I can access information about the amount of my recurring scheduled payment at any time and that I will receive notification of changes in premium payments. 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 any reason.

Return This Form & Check To:
MHS Power Account
ACH Processing Department
PO Box 2983
Omaha, NE 68103-2983
FAX (833)455-2286

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