Navia Benefit Solutions

AUTOMATIC PAYMENT (ACH) REQUEST FORM

PLEASE READ:

1. **In order for your first and subsequent recurring ACH payments to be processed, your account must be paid through the current coverage month at the time ACH is set up. This may require you to mail a payment or make a one-time online payment.**
2. Complete **Section 1** -- Participant 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. If you cannnot supply a voided check, complete **Section 2** and mail or email the form to the address below.
5. Complete **Section 3** and 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 will continue to process your ACH as normal.
8. We are not able to process incomplete forms.

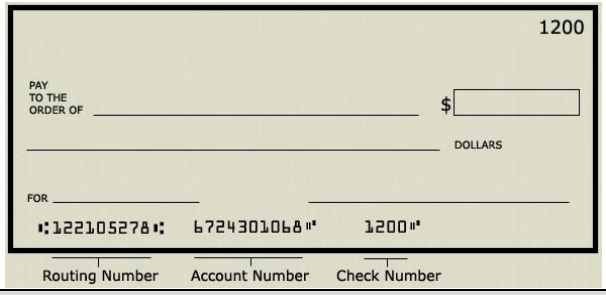
SECTION 1 - PARTICIPANT INFORMATION

☐ **ADD** AUTHORIZATION	☐ **CANCEL** AUTHORIZATION Effective:	☐ **CHANGE** AUTHORIZATION Effective:

Members Full Name (please print clearly)	**Members Social Security Number** ☐☐☐ - ☐☐ - ☐☐☐☐

SECTION 2 - BANK ACCOUNT INFORMATION

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



SECTION 3 - AUTHORIZATION SIGNATURE

Authorized Account Holder Signature	**Date**

I authorize **Navia Benefit Solutions** ("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:	**Enrollment Forms, Questions & Support Issues:**
Navia Benefit Solutions **PO Box 3961** **Seattle, WA 98124** **cobra@naviabenefits.com** **(425) 452-3490**	**Navia Benefit Solutions** PO Box 3961 Seattle, WA 98124 cobra@naviabenefits.com **(425) 452-3490**
Date Rec'd **Date Processed**	**Processor V&V**