Egyptian Area Schools Employee Benefit Trust
ACH Automatic Payment Program
Authorization Form

Payee Name (School) **Address** **Telephone #**

Application Submitted by (Name and Title):

Action (**please select one**): ☐Enroll ☐Change ☐Cancel

1. I hereby authorize Egyptian Employee Benefit Trust c/o Meritain Health, Inc., 13 Exectutive Drive Suite 19, Fairview Heights, IL 62208-1342, hereinafter called TRUST, to initiate debit entries from my account indicated below and the depository name, hereinafter called DEPOSITORY, to debit the same account.

2. Withdrawal from the following account:
   ☐Checking Account ☐Savings Account

3. I understand that the Trust offers two options for the dates premiums will be pulled. I elect to have my funds pulled on the (**please select one**):
   ☐ Last Business Day of the Prior Month ☐ 5th Day of the Month (Premium Due Date)

4. Expected Date* of first ACH withdrawal: _____
   This is to communicate your anticipated enrollment date. However, Meritain Health will confirm this date with you upon receipt and processing of application.

5. Name(s) & Email address(es) for notification of transfer to be sent: _____

Depository Bank Name:

Bank Routing Number: **Account Number:**

6. I agree to allow the TRUST to stop payment or posting of, reverse, or adjust any entry erroneously debited or credited to my account.

7. This authorization is to remain in full force and effect until the TRUST has received written notification from me of its termination in such time and manner as to afford the TRUST a reasonable opportunity to act on it.

*The following is to be filled out by the **Signer on the Account**:*
Name and Title: **Date:**

Signature:

E-Mail or Fax this form with attached documents to: EGYPTIAN@MERITAIN.COM or **716-319-5722**

Please Attach Your Voided Check Here
(Scanned images of the check are also acceptable)