North American Benefits Company
Agreement for Electronic Funds Transfer

I authorize North American Benefits Company, hereinafter called THE COMPANY, to automatically deduct monthly premium payments through an Automated Clearing House (ACH) Debit transaction from the bank account listed below on the 5th of every month. Should the 5th of the month fall on a weekend or bank holiday, the ACH Debit will be processed on the next following bank business day. This agreement will remain in effect until I give written notice to change financial institutions, terminate service, or until THE COMPANY notifies me that this service has been terminated.

Please Print

Policy Name (no abbreviations): ____

Mailing Address: ____

City, State, Zip: ____

Phone: ________________________ Email: ______________________

INSTRUCTIONS FOR ELECTRONIC FUNDS TRANSFER (EFT)

Fill in complete banking information where indicated. If routing number is unknown, please contact your bank. Without the Routing Number, **the automatic debit cannot be processed**.

Check One: New EFT Debit: ☐ Change Existing EFT Debit: ☐ (Policy Number: _______________)

Bank Name	Account Name (as it appears on the account)
Bank Account Number	Type of Account Checking: ☐ Savings: ☐
Bank ABA Routing Number	Bank Address
VOIDED CHECK *(Forms submitted without a voided check will not be accepted and will be returned.)*	

I hereby authorize THE COMPANY and the financial institution to electronically debit premium payments from my designated account. If THE COMPANY is notified of any failed transactions, THE COMPANY will automatically process a second ACH Debit for my premium payment. **If a failed transaction occurs more than once THE COMPANY will automatically terminate agreement.**

Authorized Name (Print)	Date
Authorized Signature	

THE REVERSE SIDE OF THIS FORM MUST BE COMPLETED WITH INITIAL EMPLOYEE INFORMATION

GROUP ACCIDENT PROTECTION PLAN(GAPP)

Sold Case Census

Please Print

INSURED'S NAME ***(FIRST NAME/ LAST NAME)***	***SOCIAL SECURITY #***	***GENDER***	***DATE OF HIRE***	***DATE OF BIRTH***	***FULL TIME/ PART TIME***

PREPARED BY:____ ***DATE:***_______________________________________

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North American Benefits Company
20 Valley Stream Parkway
Suite 310
Malvern, PA 19355
1-800-994-4277

TO OUR GROUP ACCIDENT PROTECTION PLAN POLICYHOLDERS

HELPFUL HINTS FROM NABCO

- *Your Occupational Accident Policy is set-up on automatic draft based on your current elected billing cycle.*
- *You will receive a copy of your current bill within two (2) weeks of your billing due date which will reflect your current employees listed under the plan and the current amount due.*
- *If you find that your billing is accurate, no further action is required and we will draft the amount reflected on your bill on the 5th of the month after your due date.*
- *After your review, if you find that any new employee(s) need to be added or any previous employee(s) need to be terminated, please complete the bottom portion of your billing statement and email back to us at GAPPPTD@nabenefits.com;, mail or Fax to (610) 995-0181.*
- *Any changes must be received by us no later than 1st of the month to allow processing time to be reflected on the current billing cycle. If receive after this date, changes and any appropriate adjustments will be reflected on the next billing cycle.*

Payments

- *If our ACH transaction for your account is returned for "Non-Sufficient Funds", we will automatically submit a second ACH transaction within 10 days.*
- *If our second attempt is also is returned, we will then require a Certified check or Money Order as a replacement for the current uncollected fund. In addition, we may also require any premiums due for the upcoming month along with a signed NO Loss Letter to continue coverage.*
- *If you change your Banking information, it is very important to notify us immediately, and we will have you complete a new ACH Authorization Agreement.:*

Please feel free to contact your NABCO account manager if you have any questions or concerns.