ACH Authorization Agreement

Use this form to authorize the payment of your coverage premiums via Automatic recurring ACH transactions (i.e., automatic withdrawals from your account).

YOUR INFORMATION		
Employer Name:		
First & Last Name:		
Address:		
Email Address:		
Phone Number:		
Last Four Digits of Your SSN:		

BANK ACCOUNT INFORMATION		
Covered Entity Gives Authorization to:	☐ Begin ACH	☐ Change Current Bank Account
Date to Begin Deductions:		
Provide Account Information Below:		
Bank Name:		
9 Digit Routing Number (Include Zeros):		
Account Number (Include Zeros):		
Account Type:	☐ Checking	☐ Savings

AUTHORIZATION & ACKNOWLEDGEMENT

The Covered Entity named above agrees to the following:

- My financial institution can receive transactions via electronic transfer and the bank information provided can serve this purpose.
- I permit Chard Snyder to initiate electronic debit entries based upon the supplied bank information above and allow them to deduct the appropriate amount due each month to keep my account up to date and in good standing.
- I will not hold Chard Snyder responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me.
- I am personally responsible for any and all fees that may be incurred and charged to me by my financial institution.
- My direct deposit may be terminated by any of the following: a written or verbal cancellation request submitted by me, more than two failed bank transactions due to: incorrect bank information, Non-Sufficient Funds, Stop Payments, and Account Closure(s).

I hereby agree to and understand the information on this form and authorize Chard Snyder to complete my request.

Signature	Date / /
Printed Name	Title

How to return your completed form:

Online	Email	Mail
Log in at app.unifyhr.com and choose Submit Your Documents	healthbenefitsupport@wexinc.com	Benefit Continuation Department P.O. Box 6764 Fargo, ND 58108-6764