Mail to:

Benefit Administrators Group
262.786.8700
700 Pilgrim Parkway, Ste 102.
Elm Grove, WI 53122

Local 3 & 2280

800.236.1154
Fax 262.786.7200

Preauthorized Payment Agreement

I hereby authorize Benefit Administrative Group (BAG) to initiate debit entries to my account indicated below for payments designated by me.

MEMBER INFORMATION

Name: ____ **Phone:**____________________________

Address:____
(street) (city) (state) (zip)

Social Security #:_________-______-___________ **Email :** ________________________________

PROVIDER DEDUCTION DISTRIBUTION

Monthly Debit First PAY DAY of the Month **Monthly**

1. **Employee $35.85 Employee & Spouse $70.62** $ _______________
2. **Employee & Children $66.66 Family $116.48** $ _______________
3. **Vision Insurance $8.25 $15.72 $24.66** $ _______________

Administration Fee: $ 3.00

Rates Effective 2/1/2010 – 2/28/2011 **Total Deduction Amount:**________________

FINANCIAL INSTITUTION INFORMATION

Full Name: ____

Address:____
(street) (city) (state) (zip)

ACCOUNT INFORMATION

Type of Account: ☐ **Checking (voided check must be attached)**
****Indicate one** ☐ **Savings Account #** _____________________

Bank Routing # ☐☐☐☐☐☐☐☐☐

This authorization agreement is to remain in effect until BAG and the financial institution named above have received written notification from me of its termination in such a timely manner as to afford BAG and your financial institution a reasonable opportunity to act on it. I also understand a $15.00 fee will be collected from my account on the next debit date should the previous debit be returned by my financial institution as Non Sufficient Funds. IN THE EVENT OF FUTURE INCREASES IN PROVIDER CHARGES, BAG IS AUTHORIZED TO INCREASE THE AMOUNT (S) OF THE ABOVE DEBITS (S0 BY SUCH AMOUNT UNLESS OTHERWISE NOTIFIED IN WRITING BY ME IN WHICH EVENT THE SUBJECT COVERAGE WILL TERMINATE) I understand BAG has the right to terminate my coverage for non-payment of premium and/or non-payment of NSF fees within 10 days of premium due date. I further understand I will not be eligible to re-enroll until ALL back premium AND NSF fees are paid.

SIGNATURES

Employee: Date: