☐ New Agreement ☐ Change in Account ☐ Terminate Direct Payment

Community College of Philadelphia

AUTHORIZATION AGREEMENT FOR AUTOMATIC DIRECT PAYMENT BY ACH DEBIT FOR HEALTH INSURANCE COVERAGE FOR THE MONTHS OF OCTOBER, 2016 AND THEREAFTER, AS SET FORTH ON CCP SCHEDULE OF RATES

I (we) hereby authorize **Brokerage Concepts d/b/a HealthNow Administrative Services** hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries for any debit entries in error to my (our) _______ Checking ______ Savings account (select one) indicated below. The frequency of the ACH Debit will be monthly occurring on the days scheduled by the Federation each year. For 2017-2018, I (we) understand those dates to be: ***09/01/17, 10/13/17, 11/10/17, 12/08/17, 01/05/18, 02/02/18, 03/02/18, 04/13/18,*** and ***05/11/18***during the period of time when health coverage premiums are due and payable (in most cases, September through the following April). If I (we) join the plan later than January, additional dates may apply.

This authority is to remain in full force and will be effective until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY a reasonable opportunity to act on it. I (we) can stop payment of any entry by notifying my (our) financial institution 3 business days before my (our) account is charged.

I (we) understand it is my (our) responsibility to ensure that proper funding is available in my (our) account at the time the COMPANY initiates the ACH Debit. If proper funding is not available, I (we) will be charged the appropriate fees incurred by the COMPANY from the bank plus an administrative fee of $10.00 (ten) dollars.

I (we) realize this agreement may be terminated by the COMPANY immediately if any debit is not honored by the Financial Institution named for any reason.

________________________________ ________________________________
(Name of Financial Institution) (Branch Address)

________________________________ ________________________________
(City) (State) (Zip)

________________________________ ________________________________
(Transit/ABA/Routing No.) (Bank Account No.)

******* ATTACH A VOIDED CHECK*******

____
Please Print Name(s)

____
(Please Print Address) (Telephone #)

____
(Signature) (Date)

Your regular payment will be deducted from your account as per your authorization above. A $2.00 processing fee will be included with your monthly payment each month when your account is debited. If the payment amount changes, we will notify you in writing through U.S. mail at least 10 days before the regular scheduled payment date.