FBMC
BENEFITS MANAGEMENT

Direct Debit (ACH) Form
For Monthly Premium Billing Payments

Participant Information ☐ New ACH ☐ Change ACH ☐ Cancel ACH

Former Employer Name: _____

Participant Name (please print): _____

Dependent Name (please print): _____

Street Address _____

City, State, ZIP _____ Telephone #:_____

Name of Financial Institution: _____

Account Type: ☐ Checking ☐ Savings ☐ Other

Routing Number ____ ____ ____ ____ ____ ___ ____ ____ ____

Account Number _____

Routing number is the first nine digits reflected on the bottom left corner of your check. Please attach a voided check of the account number that the direct debit will be drawn against. If you have selected Savings or Other, please provide a verification letter for either Savings Account or the designated Other account.

Authorization

I hereby authorize FBMC to direct debit my account on the dates due for all monthly premium billing payments, including premiums due for myself and eligible dependents. This authorization remains in effect until FBMC receives my written notification to rescind this authorization in time to allow reasonable opportunity to act on my instructions. I also understand that until such time that the bank has finalized the direct debit process, I must continue to send my monthly premiums via check or money order directly to FBMC to avoid any interruption or cancellation of coverage.

FBMC will process your scheduled monthly premium payments for direct debit from your designated account on the 22nd day of each month. Should the payment date fall on a weekend or holiday, the debit will be deducted on the next business day. If funds in your designated account are insufficient to cover the premium payment required, FBMC will require you to remit a check for the full premium amount in order to prevent termination of coverage.

Participant Signature:_____ Date: _____

Dependent Signature: _____ Date: _____

Attach Voided Check

(Note: if a voided check from your checking account or a bank verification letter for a savings or other account is not attached, this form will be returned to you.)

Return form to: FBMC Benefits Management, Inc.
Retiree and Direct Bill Department
PO Box 10789, Mail Slot 32, Tallahassee, FL 32302-2789
Fax: 1-866-836-9943 or Email: directbill@fbmc.com