BENEFIT ALLIANCE PAYMENT AGREEMENT AND BANK DRAFT AUTHORIZATION

Applicant _____ ☐ New Participant ☐ Change to Existing Plan
PLEASE PRINT

Address _____

City _____ State _____ Zip _____

Social Security # _____ Home/Cell Telephone # _____
Area Code

I authorize Special Insurance Services, Inc. (SIS), as Premium Administrator to divide and distribute funds received on my behalf as follows:

	BENEFIT	MONTHLY AMOUNT
☐	Employee Group Term Life Insurance	$ _____
☐	Spouse Group Term Life Insurance	$ _____
☐	Children's Term Life Insurance Rider	$ _____
☐	Short Term Disability Plan	$ _____
☐	Dental Plan (includes EPIC hearing benefit)	$ _____
☐	EyeMed Vision Care Plan	$ _____
☐	LegalGUARD Plan	$ _____
☐	LifeLock Identity Theft Protection Plan	$ _____
☐	Limited Accident & Sickness Plan - Tiers 1, 2, 3 or 4	$ _____
☐	First Dollar Supplemental Medical Expense Insurance	$ _____
☐	SimpleSave Rx Plan	$ _____
☐	Accident Plan	$ _____
☐	Critical Illness Plan	$ _____
	Administrative Fee	+ $2.00
	GRAND TOTAL	_____

This authorization is to honor checks drawn by Special Insurance Services, Inc. (SIS) to the Bank named below:

Bank Name _____

Address _____

Bank Draft Date: ***Circle Your Choice*** **10th 15th 20th**

(If no date chosen, bank draft will occur approximately the 15th of each month)

As a convenience to me, I hereby request and authorize you to charge my account and to pay checks or Electronic Funds Transfers drawn on my account by and payable to the order of Special Insurance Services, Inc. (SIS) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in regard to such check shall be the same as if it were a check drawn on you an signed personally by me. This authority is to remain in effect until revoked by me in writing to either SIS (Premium Administrator) or Leslie & Associates, Inc. (Plan Administrator) and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of such insurance.

This authorization is effective immediately unless otherwise specified. Furthermore, I authorize SIS to share information with Leslie & Associates, the Benefit Alliance Plan Administrator.

In addition, I hereby authorize you to disclose my address and phone number(s) on file to Special Insurance Services, Inc. and/or Leslie & Associates, Inc., the Benefit Alliance Plan Administrators for my benefit plans upon request.

YOU MUST ATTACH VOIDED CHECK OR COPY OF VOIDED CHECK HERE

STAPLE OR TAPE SAMPLE (VOID) CHECK HERE FOR CODING PURPOSES WITH THE FINANCIAL INSTITUTION'S NAME AND ADDRESS

FOR SIS USE ONLY:

INDICATE WHICH TYPE OF ACCOUNT

Type of Account ☐ Checking ☐ Savings

SIS WILL WRITE IN ROUTING AND ACCOUNT NUMBER

Transit Routing Numbers ☐☐☐☐☐☐☐☐☐

Bank Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

I hereby authorize Special Insurance Services, Inc. (Company) to make variable charges to my (our) checking or savings account identified above, and authorize the financial institution name above to withdraw funds from (debit) such account to pay Company's order accordingly for the purpose of paying monies due on policies or plans issued. Special Insurance Services, Inc. reserves the right to revoke this plan. Special Insurance Services, Inc. may, at its discretion, withdraw by means of Electronic Funds Transfer in lieu of a paper check.

I accept that this authority will remain in effect until either Special Insurance Services, Inc. (Premium Administrator) or Leslie & Associates, Inc. (Plan Administrator) has received written, dated notice of termination from me. I understand that the Premium Administrator's duty is to divide and distribute my funds. Any funds received under this agreement shall be distributed to the insurance companies or benefit providers. I understand that the Premium Administrator receives an administrative fee, as indicated above, for services rendered by them on my behalf. If any checks I remit are not paid for any reason, the Premium or Plan Administrator will be under no liability whatsoever to me, even though such non-payment may result in lapse of insurance or plan coverage. Nothing in this Payment Agreement and Bank Draft Authorization shall prevent me from increasing, decreasing or terminating future payments for the above-named benefits.

Signature (as it appears on bank account) _____ **Date** _____

Benefit Alliance Plan Premium Administration by Special Insurance Services, Inc. (SIS), P. O. Box 251749, Plano, TX 75025-1749, (972) 788-0699
Toll Free Number -1-800-767-6811 extension 30233 or 30284, Fax (972) 960-0377

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