NORTH RANCH BENEFITS TRUST
POWERED BY WARNER PACIFIC

HealthSmart
SMARTER HEALTHCARE SOLUTIONS

AUTHORIZATION FOR DIRECT PAYMENT

I am returning this authorization to **HealthSmart Benefit Solutions, Inc.**, authorizing HealthSmart and the financial institution named below to initiate entries to my checking/savings account. This authority will remain in effect until I notify you in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I can stop payment of any entry by notifying my financial institution (7) days before my account is charged. Any questions, contact HealthSmart at (800) 786-6525.

Client Information

Client Name	**Client (Division) #**		**Contact Phone Number**
Client Address	**City**	**State**	**Zip**

Financial Institution Information (Please enter name/address of bank and account you wish payments to be withdrawn from.)

Name of Bank			**Branch**
Address of Bank	**City**	**State**	**Zip**

Signature (This is your authorization for HBS to withdraw funds from your account) **Date**

Note: Withdrawals from your bank account will occur on the 1st working day of each month for which the premium is due.

Please check one: ☐ Checking ☐ Savings

Bank Routing # _____ Account # ____ _____

Please return the completed form and a copy of the voided check to:

HEALTHSMART BENEFIT SOLUTIONS, INC.
10303 E DRY CREEK RD STE 200
ENGLEWOOD CO 80112-1583
or fax to (303) 804-9490 or email NRBT@HealthSmart.com

STAPLE VOIDED CHECK HERE

(Cut here and retain for your records)

On (date) _____, I authorized HealthSmart Benefit Solutions, Inc. at 10303 East Dry Creek Road, Suite 200, Englewood, CO 80112 to initiate electronic entries to my checking/savings account and have agreed to the terms listed on the authorization. I may revoke my authorization with the company at any time by writing to HealthSmart at the address above. *If the payment amount changes, we will notify you at least 5 days before the regularly scheduled payment date.*