



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Financial Institution Information (Please enter name/address of bank and account you wish payments to be withdrawn from.)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

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.*