Milliman

For Office Use Only
Participant ID Number (list all): _____

Church Code (Location): _____

Employer Name: _____

Eder Financial
BOLD. BALANCED. TRUSTED.

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

RETIREE or ORGANIZATION NAME: _____

STREET ADDRESS:_____CITY_____STATE_____ZIP _____

I (WE) hereby authorize Eder Health and Life Benefits Services and/or any service provider (including Milliman, Inc.) used by it (hereinafter called the Company) to **automatically withdraw** from my account identified below the total amount due and to make deposits if necessary for error correction. I authorize the financial institution named below to accept such transactions initiated by the Company. The withdrawal shall be made from my account on the applicable due date.

FINANCIAL INSTITUTION NAME: _____

ABA/TRANSIT#:_____ACCOUNT #: _____

DAYTIME PHONE #:_____ DATE:_____

EMAIL of SIGNER: _____

NAME OF AUTHORIZED SIGNER: _____

SIGNATURE: _____

TAPE YOUR VOIDED CHECK HERE OR
CONFIRMATION FROM YOUR BANK OF YOUR ROUTING AND ACCOUNT NUMBER HERE

IMPORTANT! CHECK TYPE OF ACCOUNT: [ ] CHECKING [ ] SAVINGS

I am aware of my right to stop a withdrawal by notifying the Company at any time up to five (5) business days before the withdrawal date. Send your request to: bbt.support@milliman.com If an erroneous withdrawal occurs and I notify the financial institution of the error within 60 days of the issuance of my account statement, the institution must investigate and resolve the error within 45 days of notification. If the error is not resolved within the first 10 business days following receipt of my notification, my account shall be re credited for the amount in question until the investigation is completed.
(Condensed for Regulation E, Electronic Fund Transfer Act for the consumer's protection. If you want additional information, contact your financial institution).

Please return this form and the Preliminary Insurance Form to: insurance@eder.org