(800) 523-7542, option 3
Fax: 855-263-1764
premiumbilling@medcombenefits.com

Section 1 – Company Information			
Company Name			
EFT Request ☐New ☐Cancel ☐Change		Effective Date:	
Authorized Contact Name		Contact Title	

Section 2 – Financial Institution Information			
Financial Institute		Account Type	☐ Checking ☐ Savings
Financial Institute Address		City, State, Zip	
Routing Number		Account Number	

Authorization:

Medcom will process a monthly premium reimbursement on/around the 15th business day of each month. Should the payment date fall on a weekend or holiday, the funds will be deposited on the next business day. A "Pre-Payment Register" (detailed register of a payment) will be posted on Medcom's COBRA online portal.

I (we) certify I have the authority to execute this authorization. I (we) herby authorize Medcom to initiate, change or cancel EFT credit entries (deposits), and if necessary, to reverse any incorrect EFT payments made in error to the bank account indicated above. This authorization remains in effect until Medcom receives my written notification to rescind this authorization in time to allow reasonable opportunity to act on my instructions.

Section 3 – Authorization Signature	
Authorized Account Holder Signature	
Date	

Instructions for Returning this form

Please return this form, **along with a scan or photo of a voided check/bank letter** to: premiumbilling@medcombenefits.com or fax the form and **requested information** to: (855) 263-1764 or mail the form and **requested information** to:

Medcom
Attn: Premium Billing Division
Po Box 10269
Jacksonville, FL 32247