INSURANCE MANAGEMENT SERVICES

Policy Holder Name _____ Phone: _____

Address _____

City _____ State Alabama - AL Zip _____

Group _____ Cert # _____

Policy Holder Date of Birth (mm/dd/yyyy): _____

Instructions

Fill in required information. Send completed form to ECHO Health, Inc. **or** IMS using one of the return methods shown below:

ECHO:
Print, fax to: 440-835-5656
Print, mail to: ECHO Health, Inc., 868 Corporate Way, Westlake, OH 44145
Save as PDF and email (secure recommended) to: cs_requests@EchoHealthinc.com

IMS:
Print, fax to: 806-373-0995
Print, mail to: IMS, PO Box 15688, Amarillo, TX 79105
Save as PDF and email (secure recommended) to: IMS.Customer.Service@imsm.net

ECHO® Payments Simplified™ AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

I. Authorization

The member authorizes Trusteed Plans Service Corporation (through ECHO Health, Inc.) to directly deposit benefits payable to the member into the account specified below for Flexible Spending and / or Short-Term Disability and Medical / Dental. Please be aware that direct deposit setup will result in all payments to the member to directly deposit into your account, including payments for Medical / Dental / Vision claims where we are not authorized to pay the servicing provider. If you then owe that amount to the provider, you will be responsible for forwarding payment to the provider.

II. Activation

Setup requires seven (7) business days from the date of receipt to activate.

III. Documentation Requirements

The account specified below must be held by the member. A voided check must be provided with this form. We cannot accept copies of deposit slips.

IV. Termination of Authorization

This authorization remains in effect until such time as the member notifies Trusteed Plans Service Corporation in writing to terminate direct deposit procedures, ceases to be eligible for benefits under their health plan or returns to work from disability status. In the event of a new period of disability, a new agreement form would then be required at Trusteed Plans Service Corporation discretion.

V. Changes to Account Information

It is the member's responsibility to notify Trusteed Plans Service Corporation of any changes / updates to the banking information given on this form or changes of e-mail address. All changes / updates must be in writing, dated and require up to seven (7) business days from receipt to activate.

VI. Notification of Deposit

By providing an e-mail address, the member authorizes all notifications of deposit to be delivered to this e-mail address instead of by postal mail. If you do not provide an e-mail address, notification of deposit will be sent via regular postal mail.

I hereby authorize direct deposit to my checking account pursuant to the above stipulations:

Account Holder: _____ E-mail: _____

Bank Name: _____ ◯ Checking ◯ Savings

Bank Routing Number: _____ Account Number: _____

☐ I have attached a voided check for my checking account (not a deposit slip)

Date: _____ Member Signature: _____

Clear Form Print Form