BENEFITS & INSURANCE ADMINISTRATION SERVICES LLC

VANTAGE BUSINESS SUPPORT & INSURANCE SERVICES

Advanced Payment Option / Auto-Pay

The following information needs to be provided if you wish to enroll in automatic payment of your monthly medical plan contribution.

Your Name: _____ _____
first last

Company Name: _____

Address: _____
street

_____ _____ _____
city state zip code

Telephone Number: _____

Attach Voided Check Here

I hereby authorize Benefits Administration & Insurance Services, LLC to initiate debit entries for my monthly medical plan contribution due from this checking account. This request will stay in force until Benefits Administration & Insurance Services, LLC has received written notification from me of its termination in such time and in such manner as to afford Benefits Administration & Insurance Services, LLC a reasonable opportunity to act on it.

x _____ _____
signature date

Fax to: 866-830-5927 Inquiries: 877-886-8277

Or mail to: Vantage Business Support & Insurance Services
2363 Mariner Square Dr., Ste. 240
Alameda, CA 94501

Group # _____ Monthly Amount $ _____