LUMINARE HEALTH PLAN AUTHORIZATION AGREEMENT FOR DEBITS & CREDITS

COMPANY NAME:	
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):	
ADDRESS:	
CITY, STATE, ZIP:	

I/we authorize LUMINARE HEALTH BENEFITS, INC., hereinafter called COMPANY, to initiate the following Electronic Fund Transfers with the financial institution named below, hereinafter called FINANCIAL INSTITUTION.

☐ Provider Refund Credits
☐ COBRA Reimbursement Credits
☐ Other Recovered Funds *(examples: class action settlements, subrogation recoveries, RX rebates)*

Select one: ☐ Checking Account or ☐ Savings Account

FINANCIAL INSTITUTION NAME:			
BRANCH:			
CITY, STATE, ZIP:			
ROUTING ABA NUMBER: (must be 9 digits)		**ACCOUNT NUMBER:**	

EFT Notifications

PRIMARY NOTIFICATION EMAIL ADDRESSES	
REMITTANCE ADVICE/PAYMENT BACKUP NOTIFICATIONS (up to three email addresses may be included):	1)
	2)
	3)

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

NAME:	
TITLE:	
EMAIL ADDRESS:	
SIGNATURE:	
DATE:	