UNITED GROUP PROGRAMS, INC. / OptiMed
4 TERRY DRIVE, SUITE 1
NEWTOWN, PA 18940
BILLING@UGPINC.COM

EMPLOYEE
ACH PREMIUM PAYMENT AUTHORIZATION AGREEMENT

- Please **TYPE or PRINT** the information requested in **SECTION 1 and 2**. Then sign, date and mail or email to the address above with your enrollment form and a copy of a voided check.
- This is a group plan. You are not eligible if employment is terminated. In the event of termination contact UGP to stop ACH withdrawals.

SECTION 1

A. TYPE OF TRANSACTION: ☐ ADD ☐ CHANGE ☐ DELETE

B. _____ _____
NAME OF INDIVIDUAL (AREA CODE) TELEPHONE

_____ _____ _____ _____
ADDRESS CITY STATE ZIP CODE

C. _____ D. _____
EMAIL ADDRESS EMPLOYER

SECTION 2

A. _____ _____
FINANCIAL INSTITUTION NAME (AREA CODE) TELEPHONE

_____ _____ _____ _____
ADDRESS CITY STATE ZIP CODE

B. TYPE OF ACCOUNT SAVINGS ☐ CHECKING ☐

C. | | | | | | | | | | | | | | | | | . | | |
TRANSIT ROUTING / ABA NUMBER AMOUNT

| | | | | | | | | | | | | | | |
ACCOUNT NUMBER AT ABOVE INSTITUTION

EMPLOYEE – Authorizing Agreement (must be signed in order to process your enrollment)

I hereby authorize charges or deductions from the account shown above for any premium payments due. This authorization remains in effect until revoked. By signing below, I understand that the amount shown above for the coverage will be deducted on the 15th of every month or the closet subsequent business day. **I further understand that the program is automatically renewed on a monthly basis as long as the monthly premium is paid. I understand the premium may change upon the annual renewal of this plan.** If the funds are not available in my account, the coverage will be automatically cancelled. I further understand that if my employment status changes or bank account changes, it is my responsibility to notify United Group Programs, Inc. immediately.

- **Please attach a voided check for checking account or a "spec sheet" from your financial institution for savings accounts.**

_____ _____ _____
DATE APPLICANT SIGNATURE PRINTED NAME