Fermi National Accelerator Laboratory
Benefits Office
Automatic Withdrawal Authorization Agreement

Type of Agreement - Please Check Box Below:

☐ **New Election** ☐ **Change as of _____** ☐ **Cancellation**

Name: _____ **Fermilab ID #:** _____
(please print)

Home Telephone Number: _____ **Last 4 Digits of Social Security Number:** _____
(please include area code)

I hereby authorize Fermi National Accelerator Laboratory to withdraw funds from my account, for payment of my insurance premiums and, if necessary, make adjustments to correct any errors or to facilitate changes to premium amounts. I understand that this authorization will remain in effect until I provide written notification of modification or termination to Fermi National Accelerator Laboratory. Written notification must be received by Fermilab Benefits Office by the 15th of the month prior to the change effective date. Notification received after the 15th of the month will be processed the following month. I understand that I will be responsible for all non-paid premiums resulting from rejected withdrawals by my financial institution (due to insufficient funds, account closed, etc.) and any service fees incurred as a result of the rejected transaction. I understand that my insurance can be canceled for non-payment of premiums and once cancelled, will not be reinstated.

Signature: _____ Today's Date _____

Please provide the requested account information below related to the Financial Institution from which you authorize Fermi National Accelerator Laboratory to initiate fund withdrawals and/or initiate withdrawal adjustments.

Financial Institution (Bank Name): _____

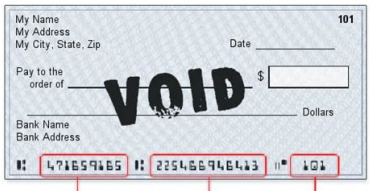
City and State (Location of Bank): _____

Type of Account: ☐ **Checking** ☐ **Savings**

PLEASE ATTACH A VOIDED CHECK OR SAVINGS ACCOUNT INFORMATION

Return Completed Form to:

Fermi National Accelerator Laboratory
Benefits Office
P.O. Box 500 M.S. 126
Batavia, IL 60510



FOR PRIVACY REASONS PLEASE DO NOT EMAIL THIS FORM

Benefits Office Use

Effective Date of First Deduction: _____ **Benefit Plan:** _____ **Deduction Amount: $**_____

Coverage Code Level (Non Medicare): ☐ **Single** ☐ **Retiree + Spouse** ☐ **Retiree + Child(ren)** ☐ **Family**

Initials: _____ **Date Entered in Bank System:** _____

Initials: _____ **Date Routed to Accounting:** _____

Verification: _____