AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

I. Authorization

The member authorizes Mid-American Benefits, Inc (through ECHO Health Inc) to directly Deposit benefits payable to the member into the account specified below for Medical. **Please be aware that direct deposit setup will result in all payments to the member to directly deposit into their account,** including payments for Medical 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

First claim payment (through ECHO) will be made by check to the member . After that, Direct Deposit can be activated.

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 Mid-American Benefits, Inc. in writing to terminate direct deposit procedures, ceases to be eligible for benefits under their 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 Mid-American Benefits, Inc. discretion.

V. Changes to Account Information

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

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

Member Signature:_____ Date: _____

- o **I have attached a voided check for my checking account**

Account Holder:_____ E-Mail: _____

Bank Name:_____ Checking/Savings:_____

Bank Routing Number:_____ Account Number: _____