

# Debit Authorization Form for the Qwest Benefit Plan(s)



What you need to do – Complete this Debit Authorization Form

_____			
Last Name	First Name	Middle Initial	
_____			
Address			
_____			
City	State	Country	Zip Code
_____			
Phone Number			
_____			
Your Bank Number _____		Your Account Number _____	
<small>(Your bank number and account number are printed on the bottom of your check or deposit slip. The account number follows the bank number.)</small>			
This is :	<input type="checkbox"/>	a Checking Account ( <u>must</u> attach a voided check)	
	<input type="checkbox"/>	a Savings Account ( <u>must</u> attach a voided deposit slip)	
To select the option, completely check the appropriate box with ink.			

I hereby authorize the Qwest Health and Life Service Center to debit the account designated for my health and/or life insurance. I understand and agree that:

- The amount for my elected benefits will be deducted on the due date shown on my confirmation statement.
- The Qwest Health and Life Service Center may make adjustments to my account for overpayments or underpayments as required.
- The Qwest Health and Life Service Center will notify me of any additional deductions that need to be made.
- I will not hold my bank liable for any erroneous debits or adjustments made by the Qwest Health and Life Service Center.
- The financial institution listed above may treat each debit the same as if it were a check written personally by me.
- If there are insufficient funds in my account to debit my payment, I will owe the billed contribution amount plus a \$20 service charge. I further understand that the payment to cover the insufficient funds must be in the form of cashier's check or money order and that this will terminate my pre-authorized debit. If a pre-authorized debit is terminated, a new authorization form must be completed to reactivate the debit. The Qwest Health and Life Service Center will send me billing coupons if the pre-authorized debit is terminated. I will be responsible to submit the monthly premium amount when due, even if I do not receive the coupons.
- This authority will remain in effect until I have canceled it in writing with the Qwest Health and Life Service Center

✕ \_\_\_\_\_  
Signature

✕ \_\_\_\_\_  
Print Name Social Security Number Date

**Return this form to:**  
**Qwest Health and Life Service Center**  
**P O Box 23606**  
**Jacksonville, FL 32241-3606**

