# Pre-Authorized Check (PAC) Draft Authorization

Return this form by:
Email: CCCSupport@HealthComp.com *Fax: 985-871-1855
Mail: HealthComp Attn. Administration Dept., P.O. Box 1590, Covington, LA 70434

## Request for Monthly Payment of Premiums by Automatic Bank Deduction

As a convenience to me, I authorize **HealthComp Integrated Solutions, LLC, Covington, LA (TIN #72-0519951)** to debit premiums and, if necessary, make adjustments for any error to my account at the Bank (or other financial institution) I have indicated below. I also authorize said Bank to debit and, if applicable, credit the amount of those entries to my account made payable to the order of HealthComp Integrated Solutions, LLC, Covington, Louisiana.

I understand and agree that:

1) My premium will be drafted the **5th** day of each month or the next business day thereafter;
2) The premium amount is shown on my latest correspondence;
3) The Bank's rights with respect to each charge will be the same as if personally executed by me;
4) This authorization will remain in effect until I provide written notification to HealthComp that I wish to revoke it. I will allow HealthComp thirty (30) days to act on this notice;
5) HealthComp and my Bank may discontinue this service; and
6) The presentation of any such debit or draft shall constitute due notice of premiums being due for a policy of insurance on my behalf and/or on behalf of my eligible dependents. I understand that should my Bank dishonor any such debit or draft for any reason, it will be my responsibility to make arrangements with HealthComp for premium payments within the grace period to prevent lapse or possible termination due to nonpayment in accordance with the terms of the policy. It is also understood that HealthComp assumes no responsibility for bank charges on these draws.
7) I further agree that my bank shall be under no obligation to furnish me with any special advice or notice of the payment of any such debit, other than my monthly banking statement.
8) I will receive notice of all transfers varying in amount from the previous transfer.

### INSURED INFORMATION (premium payor)

(Please print in ink or type)

/Northwest Airline
**Name of Insured/Employer**

Northwest Retiree Benefit Trust
**Name of Professional Membership Affiliation**

**Certificate Holder ID (SSN)**

**Month to Begin My PAC Service**

**Daytime Telephone Number**

### BANK ACCOUNT INFORMATION

**Name of Bank or Financial Institution**

**Branch** **City** **State** **Zip**

**Name(s) as Appears on Bank Account**

**Please circle one:** ***Checking*** ***Savings***

**Account Number** **Bank Transit/Routing Encoding #**

**Signature* of Premium Payor** **DATE**
(Must be identical to bank records)

***Signature** **DATE**
(If joint account, both signatures required)

HealthComp

Toll Free (888) 472-4352 • https://northwestretiree.hchealthbenefits.com

AT# 1316891