



- Complete this form and send it by mail to **MissionSquare EIP, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611; by fax to (888) 665-8495; or by email to VantageCare-Meritain@meritain.com.**
- Keep a copy for your records.

1 EMPLOYER INFORMATION

EMPLOYER PLAN NUMBER:	EMPLOYER NAME:	STATE:
ACCOUNT NUMBER:	EMPLOYER PHONE NUMBER:	

Payment will be mailed to the employer's address on file. Note: Payment must be made to the employer; payment will **not** be made to an insurance company or other third party.

2 RECURRING PAYMENTS*

Use this section to begin or to stop automated recurring payments. Payment will be sent to the employer's address on file. Note: Payment must be made to the employer; payment will not be made directly to an insurance company or other third party.

- ☐ Begin recurring payment of \$ _____
Beginning Date: Insert date you wish payments to begin ____ / ____ / ____ (MM/DD/YYYY)
Frequency (Check one): ☐ Quarterly ☐ Monthly
Ending Date: Insert date automated payments should cease ____ / ____ / ____ (MM/DD/YYYY)
- ☐ Change recurring payment amount to \$ _____
Effective date of change: ____ / ____ / ____ (MM/DD/YYYY)
- ☐ End recurring payment of \$ _____
Ending Date: Insert date automated payments should cease ____ / ____ / ____ (MM/DD/YYYY)

** Note: Payments will continue until your EIP account is depleted, unless an ending date is provided. Your EIP balance may be obtained via the employer website or by calling MissionSquare Plan Services at (800) 326-7272.*

3 ONE-TIME PAYMENT

Use this section to request a one-time payment from your EIP. Payments will be sent to the employer's address on file. Note: Payment must be made to the employer; payment will not be made directly to an insurance company or other third party.

Amount of payment: \$ _____

4 READ CAREFULLY

The undersigned certifies that the monies requested by submission of this form will be used for the payment of benefits under the employer's MissionSquare Employer Investment Program. The undersigned understands that the employer is fully responsible for the sufficiency, accuracy and veracity of all information relating to this request, and that the undersigned has authority to request payment on behalf of the employer.

Signature

Title

Printed Name

Date

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Terms and Conditions for Participating in EIP Direct Deposit

Employers in the EIP can have authorized payments deposited directly into the employer's bank account rather than receiving the payment by check. The following are the terms and conditions for participating in the EIP Direct Deposit program. You do not have to participate in the EIP Direct Deposit program to have an EIP account.

1. The employer's financial institution must be a member of an Automated Clearing House (ACH).
2. Employers must complete this authorization form to enroll in the EIP Direct Deposit program. A signed and dated form is required for processing. If employers have a joint account, both parties must sign the form.
3. Due to required security measures set by the National Automated Clearing House Association (NACHA), you will be required to take additional actions after the initial entry of your bank account information.

Once your bank account information has been added, a micro deposit transaction will be processed. A micro deposit is a random credit and debit transaction with the amount ranging between \$0.01 and \$0.99. Meritain Health, Inc. does not control the amount processed. Once the micro deposit is confirmed, you must validate the bank account by contacting our customer service team. This is a time-sensitive matter; you will have 30 calendar days to validate the amount from the time the transaction is initially processed. If you do not validate within the 30 calendar days, the bank account on file will expire and will be updated to an inactive status. ***The presence of bank account information does not guarantee a direct deposit disbursement. The account must be validated in order to be used for direct deposit reimbursement.***

4. It is the employer's responsibility to notify Meritain immediately of any changes in the status of the bank account, such as a bank account closure or a change in the bank account number. Complete this form indicating the action is a change, and provide the new information. You must follow the steps outlined in No. 3 to validate your bank account. If there is interruption in the direct deposit service, the employer will receive checks for any payments paid during that time.
5. If an electronic transfer is returned to Meritain or for any reason cannot be made to an employer's account, Meritain will investigate the cause and, if needed, will issue and mail a payment check to the employer. Until the problem is corrected, the employer will continue to receive payment checks in the mail.
6. Employers can cancel direct deposit at any time by completing this form and checking CANCELLATION. The cancellation will take effect as of the date the employer indicates, or as soon as the form is received and processed by Meritain.
7. Meritain reserves the right to cancel an employer's direct deposit services automatically upon termination of an employer's MissionSquare EIP account.
8. Direct deposit services will remain in effect from one plan year to the next until the employer cancels the direct deposit services.

If you have any questions about this form, call Meritain at (888) 587-9441.

To set up direct deposit for your MissionSquare EIP account, read the bottom of this form and fill in the information requested in Section 1 and Section 2. Return the completed form by mail to **MissionSquare EIP, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611; by fax to (888) 665-8495; or by email to VantageCare-Meritain@meritain.com.**

Type of Transaction: ☐ New ☐ Change ☐ Cancellation

1 EMPLOYER PLAN NUMBER

EMPLOYER PLAN NUMBER:	ACCOUNT NUMBER:	PREFERRED PHONE NUMBER:	EMAIL ADDRESS:
EMPLOYER NAME:			STATE:

2 FINANCIAL INFORMATION

Please include a letter from the bank that indicates the account number and routing number.

NAME(S) ON THE ACCOUNT:	☐ CHECKING ACCOUNT	☐ SAVINGS ACCOUNT
BANK OR FINANCIAL INSTITUTION:	ROUTING/TRANSIT NUMBER:	ACCOUNT NUMBER:
BANK OR FINANCIAL INSTITUTION MAILING ADDRESS:		
STREET	CITY	STATE ZIP

DEPOSITOR CERTIFICATION

I certify that I have read and understand the terms of this form. By signing this form, I authorize the employer's MissionSquare EIP account payments to be sent to the financial institution named above and deposited in the designated account.

Depositor's Signature: _____

Date: ____ / ____ / ____ (MM/DD/YYYY)

Joint Account Holder's Signature: _____

Date: ____ / ____ / ____ (MM/DD/YYYY)

Note: Any joint account holder **MUST** sign this form in order to receive payment.

Retain a copy for your records.

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