

ELECTRONIC BENEFITS PAYMENT DEDUCTION AUTHORIZATION FORM

I authorize the State of Montana Health Care & Benefits Division, and the financial institution listed below, to electronically **deduct benefits payment** for the State Employee Group Benefits Plan on a monthly basis from my (check one):

Checking Account Savings Account

This form is (check one):

For initial setup for benefits payments To make a change to an existing benefit payment

- ◆ This authorization will remain in effect until I cancel in writing.
- ◆ I understand the benefits payments deducted from my account will change automatically if the group rates change, or if any changes are made to my coverage with the State Employee Group Benefits Plan.

Signature

Date

**A voided check or savings deposit slip must be
attached here for the authorized account**

PLEASE COMPLETE THE FOLLOWING:

Print full name

Social Security Number

Return completed form to:
Health Care and Benefits Division PO Box 200130 Helena, MT 59620-0130