Concordia Plan Services
The Lutheran Church- Missouri Synod
PO Box 229007
St. Louis, MO 63122-9007

Toll Free: 888-927-7526
Email: info@concordiaplans.org
Website: ConcordiaPlans.org

ACH Authorization

Please type or print clearly in blue or black ink. Inaccurate or ineligible information will delay your payment and any related benefit enrollment.

A Member Information

Member Name (Last, First, Middle Initial) _____ Last 4 Digits of Social Security Number _____

Address _____

City _____ State _____ Zip Code _____

Email Address _____ Preferred Phone Number _____

B Payment Details

ACH Payments will be deducted on the 10th of the month for the duration of this authorization.

Monthly Amount* _____ Date of First Payment (MM/DD/YYYY) _____ Number of Payment Installments** _____

*Concordia Plans will deduct the full amount due for Concordia Health Plan (CHP) or other coverage. This amount is subject to change with annual rate changes and/or changes to coverage options or tiers.
**All benefits associated with this ACH Authorization will terminate at the end of the month in which the last payment installment was made.

C Terms

Authorization

I authorize Concordia Plans to debit my bank account as outlined in this ACH authorization. I understand that this authorization will remain in effect until the number of installments has been made or I cancel in writing, and I agree to notify Concordia Plans at least 15 days in advance of any changes.

Recourse

I have certain recourse rights if any debit does not comply with this authorization.

For example, I have the right to receive reimbursement for any ACH that is not consistent with this ACH Authorization.

To obtain more information about your recourse rights, you can visit www.nacha.org.

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D Authorization

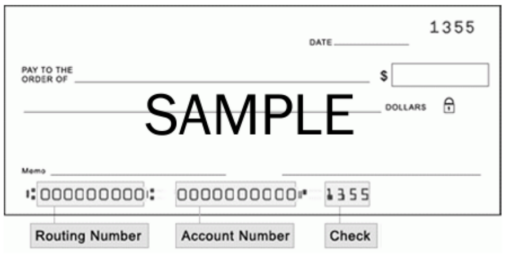
Please enter the information exactly as it appears on your checking account. Inaccurate information will delay your payment and any related benefit enrollment. If the account information listed below changes or becomes inactive, please notify Concordia Plans to avoid a disruption to benefit coverage.

Account Holder

Bank Name

Routing Number (See Sample Below)

Account Number (See Sample Below)



X _____

Payee Signature Date

Mail this completed form to:

Concordia Plans, Box 229007, St. Louis, MO 63122-9007

While emailing this form is permitted, CPS does not recommend emailing confidential information such as your banking information. Email is not secure and is subject to hacking and other crimes. We strongly recommend you mail the completed form or submit a digital signature at ConcordiaPlans.org/ACH.