AUTHORIZATION FOR CLAIMS DEDUCTIONS BY AMERIHEALTH ADMINISTRATORS, INC.
ON BEHALF OF INDEPENDENCE BLUE CROSS

Group Name _____

I (we) hereby authorize AmeriHealth Administrators, Inc. (AHA) acting on behalf of Independence Blue Cross and the financial institution named below ("INSTITUTION") to deduct the funds indicated below from my (our) account (ACCOUNT) via ACH transaction.

I (we) wish AHA to deduct the following items from the ACCOUNT.

Select all that apply.

- ❑ Health Reimbursement Account Claims
- ❑ Flexible Spending Account Claims (Medical)
- ❑ Flexible Spending Account Claims (Dependent Care)

AHA will deduct funds once a month for Medical and/or Dependent Care Flexible Spending Account Claims and/or Health Reimbursement Account Claims (within 7-10 business days following the end of each month)

I (we) agree to maintain in the ACCOUNT sufficient funds to permit these deductions. AHA will have no liability, except due to an error by the INSTITUTION or by AHA.

To terminate this authorization I (we), AHA, or the INSTITUTION must provide written notice to the other parties ten (10) business days prior to the next scheduled deduction. All notices sent to AHA must be mailed to: Controller, AmeriHealth Administrators, Inc., 720 Blair Mill Road, Horsham, PA 19044.

_____ _____
Signature Date

_____ _____
Signature (2nd signature if needed) Date

Bank Account Information

_____
Bank or Institution

_____
Bank Account Number

_____
Transit Routing Number