Healthsmart Benefit Solutions
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Plan Name: ______________________________

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

I. Authorization

The Participant authorizes Healthsmart Benefit Solutions (through ECHO Health, Inc., aka "ECHO") to directly deposit benefits payable to the Participant into the account specified below for the CMM Plan. Please be aware that direct deposit setup will result in all payments to the Participant to directly deposit into your account, including payments for the CMM Plan claims where we are not authorized to pay the servicing Provider. If you then owe that amount to the Provider, you will be responsible for submitting payment to the Provider.

II. Activation

Setup requires seven (7) business days from the date of receipt to activate.

III. Documentation Requirements

The account specified below must be held by the Participant. A voided check must be provided with this form for direct deposit to a checking account. We cannot accept copies of deposit slips. For direct deposit to a savings account, the only requirement is this signed form.

IV. Termination of Authorization

This authorization remains in effect until such time as the Participant notifies Healthsmart Benefit Solutions in writing to terminate or change direct deposit procedures or ceases to be eligible for benefits under the CMM Plan.

V. Changes to Account Information

It is the Participant's responsibility to notify Healthsmart Benefit Solutions of any changes/updates to the banking information given on this form or changes of e-mail address. All changes/updates must be in writing, dated and require up to seven (7) business days from receipt to activate.

VI. Notification of Deposit

By providing an e-mail address, the Participant authorizes all notifications of deposit to be delivered to the e-mail address instead of through postal mail. If you do not provide an e-mail address, notifications of deposit will be sent via regular postal mail. If a direct deposit fails and a credit reject notice is issued, ECHO will perform the following procedures: a) If payment is for a Provider, ECHO will contact the Provider directly to correct or issue a check; b) If payment is for a Participant, ECHO will contact HealthSmart to assist in getting corrected bank account information or mailing instructions from the Participant.

I hereby authorize direct deposit to my checking/savings account pursuant to the above stipulations:

Account Holder: ______________________ **E-mail:** ______________________

Bank Name: ______________________ **Account Type:** ______________________
(checking or savings)

Bank Routing Number: ______________________ **Account Number:** ______________________

NYSUT ID #: ______________ **Address:** ______________________

☐ I have attached a voided check from my checking account

Date: ______________ **Participant Signature:** ______________________

FOR THE PARTICIPANTS OF NYSUT