

**AUTHORIZATION AGREEMENT FOR  
PREAUTHORIZED PAYMENTS (DEBITS)**

**Please provide the Benefit Specialists of NY with the following bank account information. Monthly billed amounts will be transferred from the bank you designate below. Please attach a voided check (from business account) to identify the account you want debited.**

***PLEASE PRINT CLEARLY***

Bank Name: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Street

Suite #

City

State

Zip

Bank Telephone Number: (\_\_\_\_) \_\_\_\_\_

Account #: \_\_\_\_\_, Transit Routing # \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Your Company's Name: \_\_\_\_\_

Company Address: \_\_\_\_\_

Street

Suite #

City

State

Zip

Company Telephone Number: (\_\_\_\_) \_\_\_\_\_

Company Fax Number: (\_\_\_\_) \_\_\_\_\_

I authorize Benefit Specialists of NY to transfer funds from the account identified above. The purpose of the transfer is to pay monthly or quarterly insurance bills for the above listed employer enrolled with BSNY. I understand that the funds will be requested from my bank on or about the 24th of every month or quarter. I authorize the requested funds to be debited from the account listed above and transferred into the BSNY bank account within twenty-four hours of the request.

Name/Title: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Authorized Company Representative