TRI-STAR SYSTEMS

Authorization Agreement for Direct Pay

PART 1 – PARTICIPANT INFORMATION

Last Name:	**First Name:**	**Middle Initial:**
Email Address:	**Social Security Number:**	
Address: ***Street***		
City	***State***	***Zip Code***

PART 2 - BANKING INFORMATION

Financial Institution Name:	**Type of Account: (check one)** ☐ **Checking** ☐ **Savings**
Routing Number: (9 digit number on bottom of check)	**Account Number:**

PART 3 - PARTICIPANT AUTHORIZATION AND SIGNATURE

I hereby authorize Tri-Star Systems to initiate debit transactions from the account indicated on the attached ***voided check*** *for monthly Insurance Premium Continuation Payments. I understand that premiums will be deducted from this account on the 1st of each month in which they are due.*

Signature: _____ Date:_____

Please return this signed form along with a voided check to:
Tri-Star Systems
Attn: COBRA
16253 Swingley Ridge Road, Suite 210
Chesterfield, MO 63017
Phone: (800) 727-0182, Option # 2
Fax: (314) 985-0276 E-mail: cobra@tri-starsystems.com

It is your responsibility to notify Tri-Star Benefit Systems, Inc. immediately of any changes in your financial institution (i.e., change of account number, closure of account, etc.)
To cancel your participation in Direct Pay, you must notify Tri-Star in writing or change it online through your account login.