



Payment Authorization Form

I hereby authorize Solstice Benefits, Inc. to charge the (*Monthly*) premium to the following checking account for my current and future payments until I revoke this authorization in writing.

Checking Account Option	
Name on the Account:	Business Checking Account <input type="checkbox"/> Personal Checking Account <input type="checkbox"/>
Bank Routing #:	_____
Account #:	_____

Group Name: _____

Billing Address: _____

Email Address: _____

Authorized Name (Printed): _____

Authorized Signature: _____

(Your payment will be deducted from the account listed above the 1st business day of month)

Group Number (s) _____

(If previously provided, or to be added by Solstice)

Today's Date: ___ / ___ / _____

Please complete form and return to:
Solstice Benefits, Inc.
P.O. Box 19199, Plantation, FL 33318
Phone: 877-760-2247, Fax: 954-370-1701