OREGON INDEPENDENT CHOICE PROGRAM CASH BENEFIT FORM

AUTHORIZATION FOR AUTOMATIC WITHDRAWAL FROM CASH BENEFIT ACCOUNT

Payroll Agent: **Acumen Fiscal Agent, LLC.**
5416 E. Baseline Rd., Suite 200
Mesa, AZ 85206

Phone: **(866) 235-4745**
Fax: **(844) 343-2590**
Email: **enrollment@acumen2.net**

I hereby authorize Acumen Fiscal Agent, LLC, hereinafter called Company, to initiate debit entries for the purpose of collecting my cash benefit as calculated in the OR ICP Benefit Calculation and, if necessary, credit entries for the purpose of correcting an erroneous debit previously initiated from my account indicated below. I further authorize the Financial Institution named below to accept such entries and to debit or credit the amount thereof to such account. I agree the ACH transactions I authorize, comply with Oregon and US Law.

For ***New Accounts, Change of Accounts*** **or** ***Cancellation***, complete this top part. Attach a **voided check** for checking account(s) or contact your bank to have them provide you with a printout that provides the routing number and account information for your savings accounts. Any changes to your account(s) must be submitted immediately!

☐ **New Account** ☐ **Change of Account** ☐ **Cancellation**

☐ **Checking** (attach a voided check)
☐ **Savings** (attach printout from bank with routing and account information)

I authorize a monthly debit on the 7th of each month (or the following business day if the 7th falls on a weekend or bank holiday) in the amount calculated by the OR ICP Benefit Calculation of:
$_____________.

_____________________________________ _____________________________________

Financial Institution Name Branch Name and Phone Number

_____________________________________ ____________________________ ________ ___________

Address City State Zip

__________________________ ______________________

Account Routing Number Account Number

To only ***Change the Amount Withdrawn*** complete the below items.

☐ **Change of Amount Withdrawn**

I authorize a change in the monthly debit amount withdrawn on the 7th of each month (or the following business day if the 7th falls on a weekend or bank holiday) in the amount calculated by the OR ICP Benefit Calculation, beginning Month/Yr: _____/_____, in the amount of: $_____________.

This authority is to remain in full force and effect until Company and Financial Institution has received written notification from me of its termination in such time and manner as to afford Company and Financial Institution a reasonable opportunity to act upon it.

By signing below, I hereby authorize and agree that Company may withdraw my ICP Cash Benefit amount from the bank account designated above.

____ ______________________________________

Print Name Phone Number

____ ______________________________________

Signature Date

NOTE: Wet signature is required