Tower Administrative Services, Inc.
8 Marticville Road
Lancaster, PA 17603

(717) 872-8576
(800) 437-1670
Fax (717) 584-0277
Upload: https://www.towerinsur.com/Agent/

PREAUTHORIZED PAYMENT AGREEMENT

I hereby authorize Tower Administrative Services, Inc. (TAS) through its designated financial institution (DFI) to initiate debit entries to my sub-account indicated below for payments designated by me.

EMPLOYEE INFORMATION

Employee Name (Last, First, Middle Initial)	Email Address

Employee Home Address (Street, City, State, Zip)

Social Security Number	Home Phone #	Work Phone #
– –	( ) –	( ) –

I authorize the following individual to speak on my behalf regarding these deductions:_____

PROVIDER DEDUCTION DISTRIBUTION

☐ **Monthly Debit**: ☐ 5th ☐ 15th ☐ 20th ☐ 25th (Select Date)

COMPANY NAME / ADDRESS	POLICY / ACCOUNT #	MONTHLY AMOUNT
1. Manhattan Life	Short Term Disability	
2.		
3.		
4.		

Processing Fee:	$4.00
Total Deduction Amount:	4

FINANCIAL INSTITUTION INFORMATION

Full Name (Include branch if applicable)

Address (Street, City, State, Zip)

ACCOUNT INFORMATION

Type of Account (Indicate One)

☐ Checking **(voided check *must* be attached)** _____

☐ Savings Account # _____

Bank Routing # (If savings)

SIGNATURES

Employee Signature *(Premium Payor)*_____ **Date**_____

Agent Name *(Please Print)*_____ **Agent Writing #** _____

This authorization Agreement is to remain in effect until TAS has received written notification from me of its termination in such a timely manner as to afford TAS and its DFI a reasonable opportunity to act on it. My sub-account is non-interest bearing. I also authorize the distribution of that AMOUNT to the company(s) or its' agents as indicated above or assigns. I understand if there are insufficient funds, providers will be paid in set order. Unless otherwise indicated in writing, DFI handles the funds and TAS's association with any insurer listed is to facilitate distribution as directed by and paid for by me as specified above.

If a regularly scheduled debit is returned by my Financial Institution as Non-Sufficient Funds (NSF). I authorize a debit to my account again for the missing NSF debit amount plus an additional $25.00 fee on the next scheduled debit date that is a minimum of 14 calendar days from that NSF Debit date. I further authorize TAS/DFI to disclose my social security number and furnish a copy of this form and other non-public personal information to third parties as necessary to provide the services hereunder.

In the event of future increases to or cessation or Insurer charges, I authorize TAS through their DFI to increase or reduce the amount(s) of the above debit by such amount unless notified in writing by me.