

Managed Care Automated Clearing House (ACH) Reimbursement Authorization

StarNet Insurance Company

Use this form to set up or make changes to Automated Clearing House (ACH) claim reimbursements.

Check all that apply: ☐ Setup ACH ☐ Cancel ACH ☐ Change bank ☐ Change account number Today's Date:

Section 1 – Policyholder/Reinsured Information

Name:

Address:

City:

State:

Zip:

Primary Contact Name:

Contact Phone:

Contact Email:

Contact Fax:

Section 2 – Bank Information

Bank Name:

Address:

City:

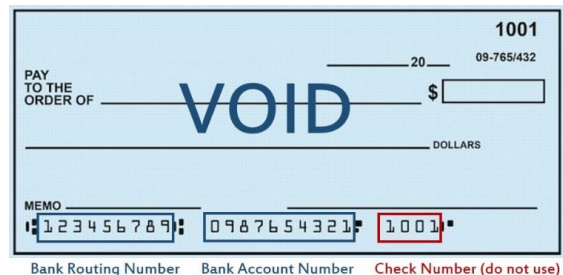
State:

Zip:

Bank Routing Number (9 digits):

Bank Account Number:

IMPORTANT: You must attach either: (1) a voided check or (2) a bank verification letter showing the same information.



Section 3 – Authorized Signature

We will call you to verbally confirm your banking information, as an added layer of protection against fraud. If the person we should call to confirm banking information is different than the Primary Contact listed in Section 1, please provide their information below. **NOTE:** This person should hold a financial role in your company and be familiar with your bank accounts for verification purposes.

Company Contact/Representative - Name:

Phone:

Email:

I hereby authorize StarNet Insurance Company to make all claim reimbursement payments due under the policy/agreement listed above by ACH. This authorization will be effective until further written notice from the Policyholder/ Reinsured, or another legally authorized representative, is received by StarNet Insurance Company.

To correct any overpayments, I hereby authorize the reversal of any amounts deposited in error.

Signature of Authorized Representative of the Policyholder/Reinsured

Date

X _____

Print Name:

Title:

Email this completed form AND your bank verification letter or voided check to: BAH_ACH@BerkleyAH.com.

Please allow processing time for set up before ACH claim payments can begin. Remember, we cannot process your request without a voided check or bank verification letter. If you have any questions, please call your Berkley Accident and Health representative.

Completed By (Name):

Email: