Fenyx Health

ACH TRANSFER REQUEST FORM

Complete this form and send to us at:

Secure Upload: go.fenyxhealth.com/securefileupload

Mail: Fenyx Health, Attn: MSA Custodian
PO Box 135, Winfield, PA 17889

CLEAR THIS FORM

1 — Account Holder Information

First name*	Last name*		
Fenyx Health member ID number*	Email address*	Daytime phone*	
Street address*	City*	State* Select...	Zip code*

2 — Transfer Information *(you must be the owner/account holder of both accounts)*

FROM Fenyx Health MSA bank account number*	Amount to transfer FROM Fenyx Health account*
TO financial institution name*	TO financial institution routing number*
TO financial institution account type* ☐ Checking ☐ Savings	TO financial institution account number*

3 — Account Holder Acknowledgment and Authorization

I authorize Fenyx Health Insurance Company and Piedmont Payment Services LLC to initiate electronic transactions to satisfy the transfer of assets in the manner described above. Such transactions are made through automated clearing house ("ACH") associations, and are subject to the operating rules and regulations of the National Automated Clearinghouse Association. I understand that I may revoke this authorization by giving at least sixty (60) days written notice of cancellation to Fenyx Health at the address listed above, and that the revocation will not apply to transactions initiated prior to Fenyx Health's receipt of such notice. I am the owner of the accounts named above, have the legal right to provide this authorization and certify that all information provided by me is true and complete. I understand that I may be subject to tax and/or penalties if I transfer funds for any reason except 1) reimbursing myself for qualified medical expenses I incurred or 2) transferring funds to another MSA bank account where I am listed as the account holder.

Account holder signature*	Date*