STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS
REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

NAME (AS SHOWN ON YOUR BILL)			MEMBER ID NUMBER OR LAST 4 DIGITS OF SSN
ADDRESS (AS SHOWN ON YOUR BILL)	CITY	STATE	ZIP CODE
NAME OF FINANCIAL INSTITUTION	BRANCH		
ADDRESS OF FINANCIAL INSTITUTION	CITY	STATE	ZIP CODE

PLEASE DEDUCT MY AUTOMATIC PAYMENT FROM MY

☐ CHECKING ACCOUNT	CHECKING ACCOUNT ROUTING NUMBER	CHECKING ACCOUNT NUMBER
☐ SAVINGS ACCOUNT	SAVINGS ACCOUNT ROUTING NUMBER	SAVINGS ACCOUNT NUMBER

I (we) hereby authorize the Office of Group Benefits to initiate debit entries to my (our) checking/savings account at the depository financial institution named above and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. This authority will remain in effect until I notify you in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I can stop payment of any entry by notifying my financial institution three (3) days before my account is charged.

SIGNATURE _____ DATE _____

PLEASE ENCLOSE A VOIDED CHECK OR LETTER FROM YOUR BANK ALONG WITH THIS FORM AND YOUR FIRST MONTH'S PAYMENT. FAILURE TO DO SO WILL PREVENT THE OFFICE OF FINANCE AND SUPPORT FROM SETTING UP YOUR AUTOMATIC BILL PAYMENT.

MAIL TO:

Fiscal Department – ACH Processing
Office of Group Benefits
P. O. Box 44036
Baton Rouge, LA 70804

YOU MAY ALSO EMAIL A SCANNED COPY OF THIS FORM AND VOIDED CHECK TO:
OFSS-OGB.Invoicing@la.gov
ALL DOCUMENTS SHOULD INCLUDE MEMBER ID# OR THE LAST 4 DIGITS OF YOUR SOCIAL SECURITY NUMBER
PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.