



Network Health Plan
Premium Payment by Electronic Funds Transfer Form

Bank Withdrawal Authorization

Group Name _____

Your Network Health Plan premium payment will be withdrawn on the 7th of each month from the designated checking account. If the 7th falls on a weekend or holiday, the payment will be withdrawn on the following business day. Please be sure to deduct this payment from your records.

You will receive your monthly invoice about the 24th-25th of each month, which will remind you of the automatic payment. The invoice will reflect the amount of the automatic deduction.

Checking Account information:
Please attach a voided check for the designated account.

Financial Institution _____

Routing Number _____

Account Number _____

I authorize Network Health Plan to make debit entries to my account. Please note that funds will not be withdrawn from a savings account.

This authorization is to remain in full force until Network Health Plan and the Bank have received written notification from the group of its termination in a time and manner to afford Network Health Plan and the Bank reasonable opportunity to act on it. You have the right to stop payment of a debit entry by notifying the Bank in a time and manner to afford the Bank reasonable opportunity to act on it prior to charging the account. After the account has been charged, you have the right to have an erroneous debit credited to your account, provided written notice of the debit error is sent to the bank within 15 days following issue of the account statement or 45 days after posting, whichever occurs first.

Name as it Appears on the Account

Authorized Signature

Date

Note: Please notify Network Health Plan immediately if any changes are made to your designated bank account. Failure to notify us may result in the termination of your coverage if payment is not debited to your account.