Network Health
Premium Payment by Electronic Funds Transfer Form
Financial Institution Withdrawal Authorization

Group Name: _____

Your Network Health premium payment, due on the first of the month, will be drawn on the seventh of each month from the designated account. Should the seventh fall on a weekend day or Federal Reserve Bank holiday, the payment will be drawn on the next business day. Please be sure to deduct the premium amount from your records. You will continue to receive your monthly premium invoice to remind you of the automatic payment. The invoice will reflect the amount of the automatic deduction.

Please attach a voided check if you are selecting a checking account to draft from.

Financial Institution: _____

Routing Number: _____

Account Number: _____

I hereby authorize Network Health to make debit entries to the above referenced account.

This authorization is to remain in full force until both Network Health and the above referenced financial institution receive written notification from the account holder of its terminated in a time and manner to afford Network Health and the financial institution reasonable opportunity to act on it. You have the right to stop payment of a debit entry by notifying the financial institution in a time and manner to afford the financial institution reasonable opportunity to act on it prior to charging the account.

_____

Name as it Appears on the Account

_____

Authorized Signature **Date**

Note: Please notify Network Health immediately if any changes are necessary to this process. A fee of **$25** may be assessed if any account is closed or insufficient funds are available at the time the debit is processed. Debit failure will require you to make alternate payment arrangements for the current premium month and you may need to reapply for automated withdrawal before processing will resume.

FAX TO 920-720-1904