Employer Electronic Funds Transfer Form

This form authorizes HealthPass to automatically deduct payment for your monthly cost of coverage from your business checking account.

Please complete the items below and return this form to HealthPass via fax, mail or email.

Your checking account information:

Business Name (as it appears on account):_____

Bank Name:_____

Bank Routing Number:_____

Bank Account Number (must be a checking account)**:**_____

HealthPass ID#:_____

❑ Please check if this is a one-time only payment

Amount: $ _____ **Check #:** _____

_____

Signature of Authorized Representative **Date**

EFT Authorization

I hereby authorize HealthPass to initiate EFT from my account until further notice, for the payment of my monthly cost of coverage. Withdrawals occur on or about the 1st of every month. I understand that if I make changes to my banking arrangements during this timeframe that the successful completion of the EFT may not occur.

Begin my monthly EFT payments _____
Coverage Month

_____

Signature of Authorized Representative **Date**

PLEASE ATTACH A VOIDED CHECK

HealthPass
7120 Lake Ellenor Drive
Orlando, Fl 32809-5721
Member Services: (888) 313-7277
Billing: (888) 313-7010
Fax: (888) 354-7277

For Internal Use Only
Initials:_____
Date: _____
Time:_____