Harvard Pilgrim Health Care

ACH AUTHORIZATION FORM

COMPANY NAME_____

STREET ADDRESS_____

CITY_____STATE_____ZIP CODE_____

TELEPHONE_____FEDERAL ID#_____

BANKING INSTITUTION_____

BUSINESS ACCOUNT NUMBER_____

BUSINESS ACCOUNT NAME _____

BANK ROUTING NUMBER_____

PLEASE SELECT BANK ACCOUNT TYPE ☐ CHECKING ☐ SAVINGS

Note: HPHC only accepts ACH requests from Business Accounts.

- ☐ **Monthly Premium**
- ☐ **Monthly ASO Administrative Fee**
- ☐ **Monthly Level Funded Amount**
- ☐ **Weekly ASO Claims**

PLEASE ATTACH A VOIDED CHECK AND FORWARD TO YOUR SALES EXECUTIVE AS PART OF THE NEW SOLD GROUP PAPERWORK

I HEREBY AUTHORIZE HARVARD PILGRIM HEALTH CARE, INC. AND ITS AFFILIATES TO MAKE ELECTRONIC FUNDS TRANSFERS FROM MY BUSINESS CHECKING OR SAVINGS ACCOUNT. I HAVE THE RIGHT TO TERMINATE THIS AGREEMENT BY SENDING A THIRTY-DAY WRITTEN NOTIFICATION OF MY INTENTION. I HAVE READ THIS AGREEMENT AND FULLY UNDERSTAND MY RIGHTS AND OBLIGATIONS UNDER THIS AGREEMENT.

SIGNATURE_____DATE_____

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care and its affiliates, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.