Western Health Advantage

2349 Gateway Oaks Drive, Suite 100
Sacramento, California 95833
916.563.3180 | 888.227.5942 toll-free
916.563.3182 fax

One-Time eCheck Payment Authorization

This is permission for a single transaction only. As an authorized signor on the Depository Account presented, by completing and signing this form you give Western Health Advantage (WHA) permission to charge/debit your account, one-time, for the amount indicated on or after the indicated date.

Accountholder's Full Name: _____

Billing Address: _____

City, State, Zip: _____

Account Type: ☐ Checking ☐ Savings

Bank Routing Number: _____

Bank Account Number: _____

Amount Authorized: _____

Email address: _____
(optional for electronic receipt)

I acknowledge that a minimum Non-Sufficient Funds (NSF) fee of $25 may be charged by WHA to me in the event there are insufficient funds available at the time the eCheck payment is submitted. I authorize WHA to charge/debit the account indicated in this authorization form according to the terms outlined above. This payment authorization is for the Binder payment of health insurance policy provided by WHA, for the amount indicated above only, and is valid for one-time use only. I certify that I am an authorized signor on this Depository Account.

Authorizing Signature: _____ Date: _____