One-Time eCheck Payment Authorization Form

Mail to: Western Health Advantage, Attn: Sales
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.1338
Questions: 916.563.3198 or 888.499.3198 (toll-free)

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.

Account Holder Name _____

Billing Address _____

City, State, Zip _____

Account Type ❑ Checking ❑ Savings

Bank Routing/Transit # (first 9 digits) _____

Bank Account # (next 10 digits) _____

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.

Authorized Signature _____ Today's Date _____