EFT Authorization Form

FOR ELECTRONIC FUNDS TRANSFER PAYMENTS

Western Health Advantage

Mail your completed form to: Western Health Advantage
Premium Billing
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833

Group Name/Group # _____

Subscriber ID # (Individual only) _____

Coverage Month to Begin Paying by EFT _____

Bank Name/Account Holder Name _____

Bank Routing/Transit # (first 9 digits) _____

Bank Account # (next 10 digits) _____

The undersigned hereby authorizes Western Health Advantage (WHA) to initiate and receive payment via electronic funds transfer (EFT) from the above-referenced Bank Account. **I understand and agree: that the funds will be transferred to WHA on or about the 28th of each month for the next monthly premium** and any non-sufficient funds (NSF) fees, reinstatement fees or overdue premiums outstanding; that this signed Authorization must be received by WHA before the 17th of the month in order to initiate EFT for the following month and will continue every month thereafter until (a) WHA elects to terminate the EFT, (b) the Group/member ceases to be insured by WHA or (c) the Group/member terminates this Authorization; and that WHA may terminate this Authorization without notice if it is notified of NSF by the bank or for any other reason. [Note: if an EFT fails due to NSF, your coverage will be terminated.] I understand that I may terminate future EFTs by notifying WHA in writing at the address above on or before the 17th of the month prior to the month I wish to terminate the EFT. All terms and conditions of the GSA/Evidence of Coverage between Group/member and WHA remain in full force and effect.

After your EFT begins, you will continue to receive paper bills. You can elect paperless bills and receive an email billing reminder for each account. To change to this option, log on to MyWHA.org (individual) or MyWHAGroup.org (group).

_____ _____
Authorized Signature Today's Date

_____ _____ _____
Printed Name Title Contact Phone

To be completed by subscriber with a third party paying premium by EFT on your behalf:

I understand that I am responsible for making required premium payments to maintain my coverage. If I have made arrangements for a third party to pay my premium, I understand that I remain ultimately responsible for payment and my coverage may be terminated as allowed by law if payments are not made. I understand that if a third-party payor cancels EFT, I must make alternate payment arrangements prior to my next due date, and I understand that WHA will not notify me of this change.

_____ _____
Subscriber Printed Name Contact Phone

_____ _____
Subscriber Signature Today's Date

PLEASE ATTACH A PRE-PRINTED VOIDED CHECK MATCHING THE BANK INFORMATION ABOVE.