NEW GROUP
ELECTRONIC FUNDS TRANSFER (EFT)
AUTHORIZATION FORM

This form may be used to authorize electronic debit payment from your bank account. Please complete the requested information and return this form with your completed employer coverage application. Any missing information may delay the processing of your application and/or payment.

Employer Information

Group Name:		
Group Number:		
Group Representative Name:		
Group Confirmation Email:		
Group Address:		
City	State	Zip Code

Financial Institution Information (***Required***)

Name of Financial Institution:	
Account Type (*Personal/Business*):	Banking Type (*Checking/Savings*):
9-Digit Bank Routing Number:	Total Amount Due:
Bank Account Number:	
Name on the Account:	

Signature Required

I authorize MediExcel Health Plan to initiate **a one-time debit to the bank account** shown above. If this item is returned unpaid, I authorize MediExcel Health Plan to mail a bill to the address on record and the group will be responsible for making the payment by check or money order, and for paying any return item service charges in order for coverage to become effective.

By signing this form, I agree to the terms and conditions stated and acknowledge that I have received a copy of this form.

Group Representative Signature	Print Name	Date

Please retain a copy of this form for your records.