

## 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:		
9-Digit Bank Routing Number:	Total Amount Due:	
Bank Account Number:		
Account Type (Personal/Business):	Banking Type (Checking/Savings):	
Name on the Account:		
Signature Required		
I authorize MediExcel Health Plan to initiate <u>a one-time debit to the back</u> MediExcel Health Plan to mail a bill to the address on record and the grand for paying any return item service charges in order for coverage to  By signing this form, I agree to the terms and conditions stated and ack	oup will be responsible for making the become effective.	payment by check or money order,
Group Representative Signature	Print Name	Date

Please retain a copy of this form for your records.

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