Employer Electronic Funds Transfer Form

This form authorizes HealthPass to automatically deduct payment for your monthly cost of coverage from your business checking account.

Please complete the items below and return this form to HealthPass via fax, mail or email.

Your checking account information:

Business Name:_____

Bank Name:_____

ABA Number/ Check Routing Number:_____

Bank Account Number (must be a checking account):_____

HealthPass Group #:_____

Ongoing

☐ Please check if this is a recurring monthly payment

Recurring EFT Authorization

I hereby authorize HealthPass to initiate EFT from my account until further notice for the payment of my monthly cost of coverage. Withdrawals occur on or about the 1st of every month. Please call 888.313.7010 to notify us of any change in this request.

Begin my monthly EFT payments _____

Coverage Month

_____

Signature of Authorized Representative **Date**

One Time

☐ Please check if this is a one-time only payment

Amount $_____

I hereby authorize HealthPass to immediately initiate this one-time EFT from my account for the payment of my monthly cost of coverage. Please call 888.313.7010 to notify us of any change in this request.

_____

Signature of Authorized Representative **Date**

HealthPass New York
80 Pine Street, 29th Floor
New York, NY 10005
Client Services: 888.313.7010
Billing: 888.313.7010
Fax: 212-252-7448
billing@healthpassny.com

PLEASE ATTACH A VOIDED CHECK

For Internal Use Only
Initials:_____
Date:_____
Time:_____