

# ACH Payment Form

- Form must be COMPLETED in FULL, SIGNED and DATED for processing
- E-mail: underwriting@calchoice.com

## Step 1 - COMPLETE GROUP INFORMATION

<b>Company Name</b>			
<input type="text"/>			
<b>Address</b>			<b>Suite #</b>
<input type="text"/>			<input type="text"/>
<b>City</b>	<b>State</b>	<b>ZIP Code</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>Phone # (XXX) XXX-XXXX</b>	<b>Company Contact E-mail Address</b>		
<input type="text"/>	<input type="text"/>		

## Step 2 - COMPLETE BANK INFORMATION

<b>Bank Name</b>	<input type="text"/>	<b>Account Type</b>	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
<b>Account Holder Name</b>	<input type="text"/>			
<b>Account #</b>	<input type="text"/>	<b>Routing #</b>	<input type="text"/>	
<b>First Month's Premium</b>	<input type="checkbox"/> I want the group's first month's premium deducted from the account listed above, based on the total amount listed on the Final Premium Deposit Statement.	<b>OR</b>	<input type="checkbox"/> Indicate amount to be debited	\$ _____
<b>Recurring Payments</b>	<input type="checkbox"/> By checking this box you are giving permission to <i>CHOICE</i> Administrators® to initiate payments on your behalf from the above payment account. The payment amount will automatically be deducted from your account on the due date. Recurring Payment amount changes based on the current outstanding premium for the given month.			
To ensure successful processing of your online payment, please advise your bank of <i>CHOICE</i> Administrators ACH ID (0330115986)				

## Step 3 - ATTACH VOIDED CHECK

### ATTACH VOIDED CHECK HERE

This information will be used to verify the account and routing numbers listed above.

## Step 4 - COMPLETE AUTHORIZATION

I hereby authorize *CHOICE* Administrators to debit the account as indicated above. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as 24 hours after notification of group health plan approval. I understand that it is my responsibility to monitor my bank charges and verify that payments are processed properly. I agree not to dispute this billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.

<b>Authorized Representative's Name</b>	<input type="text"/>	<b>Phone # (XXX) XXX-XXXX</b>	<input type="text"/>
<b>Signature</b>	<input type="text"/>	<b>Date Signed (MM/DD/YYYY)</b>	<input type="text"/>

**INTERNAL USE ONLY**    Current: \$ \_\_\_\_\_    Future: \$ \_\_\_\_\_    Recurring

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