

# Group Authorization Agreement for Recurring Electronic Fund Transfers (EFT)



**Please note: The first month's payment cannot be made by EFT, a binder check is required to effectuate coverage.**

This form must be completed and returned at least 10 business days prior to the payment due date. Until then, please make payments by check to prevent your account from becoming past due. See the next page of this form for complete instructions.

## Employer Information

Employer \_\_\_\_\_

Group No. (if known) \_\_\_\_\_ Subgroup No. \_\_\_\_\_ Fed. ID No. \_\_\_\_\_

Business Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Email Address for Billing Contact Person \_\_\_\_\_

Notification Preference (fax or email notification is required)    Fax    Email

## Bank Information

Employer's Financial Institution \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Account No. \_\_\_\_\_

Nine-digit Financial Institution Routing Number (for bank use only) \_\_\_\_\_

Effective Month Requested (transaction occurs on the first business day of the month) \_\_\_\_\_

**Please attach a voided check (required).**

## Disclosure

We authorize and direct PacificSource Health Plans to withdraw funds each month from our bank account stated above. This authorization will remain in effect until terminated by either party. By signing below, I acknowledge that I have read and agree to the responsibilities outlined on the next page of this form.

Authorized Representative of Employer (print name) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_

## For PacificSource Administrative Use Only

EFT Effective Date \_\_\_\_\_

Processed by Membership Services \_\_\_\_\_ Date \_\_\_\_\_

## Group Request/Authorization for Electronic Funds Transfer Arrangement

As an added service to you, we offer the option to pay your group policy premium by Electronic Funds Transfer (EFT).

### Requirements

To participate in our EFT Payment option:

- You agree to provide your insurance payments to us via electronic funds transfer.
- EFT payments can begin the month you request, provided we receive all necessary forms and information no later than 10 business days prior to the payment due date. The first month's premium cannot be paid by EFT, a binder check is required to effectuate coverage.
- You agree to provide us with an email address or fax number for notification of billing amounts.

### Our Responsibilities

- We will mail you a billing statement for your insurance premiums by the 18th of the month prior to the month being billed. The month your policy renews, your billing statement may be mailed later.
- On the last business day of the month, we will notify you via email or fax of the amount to be debited from your bank account.
- On the first business day of each month, we will debit your designated bank account via electronic funds transfer (EFT) for the full amount due for insurance premiums as indicated in the above notice.
- Requests for cancellation of the EFT payment arrangement must be received in writing at least 10 business days before the next scheduled draft date.

### Your Responsibilities

- You will provide us with the information and permissions we need to establish ongoing, scheduled EFT transactions from your designated bank account.
- You will provide us with any enrollment changes, in writing, as early as possible, but no later than the 14th day of the month prior to the effective date of the change. Changes submitted after the 14th will be reflected on the following invoice.
- You will ensure that your designated bank account contains sufficient funds to allow the EFT transaction to take place on the first business day of each month. See "Insufficient Funds" below for more information.
- Please do not send EFT form with your invoice. Please refer to the bottom of this page to send this form and a voided check via email, mail, or fax.

### Insufficient Funds

If we attempt to debit your bank account on the designated day and the account's funds are insufficient, the transaction will not be completed. We will contact you by phone to discuss the situation and agree on whether you will send a replacement check by mail or PacificSource will draft 2 months' premiums on the next scheduled draft date.

If payment is impeded by insufficient funds twice in any 12-month period, we will terminate this payment arrangement.

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Toll-free: 866-999-5583  
Fax: 541-225-3642  
Email: [Membership@PacificSource.com](mailto:Membership@PacificSource.com)  
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