

# ELECTRONIC FUND TRANSFER

(This form must be completed and signed if this Monthly Billing Option was selected)

<b>A. PERSONAL INFORMATION</b>			
Applicant's Last Name	First Name	M	State or Country of Birth
Home Address			Home Phone Number (     )
City	State	Zip	County
Applicant's Occupation	Applicant's Employer		Business Phone Number (     )
Applicant's Social Security Number	Driver's License Number (if applicable)		State Driver's License Issued (ex. Florida)
Spouse's Occupation	Spouse's Employer		Business Phone Number (     )
Spouse's Social Security Number	Driver's License Number (if applicable)		State Driver's License Issued (ex. Florida)
<b>B. ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION</b>			
1.	Account Holder's Name	Account Number	
	2.	Bank's Name	Bank's Address
			_____
3.	Routing Account Number	Routing number can be found on the bottom left-hand side of the check. Please write the first 9 numbers after the colon in box number 3.	
Please attach a voided check here. All withdrawals will be on the first of the month.	I hereby authorize the Plan and the bank named above to initiate entries to my checking or savings account. This authority will remain in effect until I notify Care Access in writing and Care Access receives such notice to cancel it in such time as to afford reasonable opportunity to act on it. I understand that if the necessary funds are not available in my account on the first of the month to execute the automatic entry, I will be terminated effective the first of the month in which there are insufficient funds available following the 10-day grace period. I also understand that any changes or cancellations to my account require a 15-day written notice to Care Access. Following the grace period, I will be responsible for any medical services received after the termination date.		
	Signature of Account Holder: _____		Date _____