Initial Payment Authorization form*

SECTION A: BUSINESS BILLING INFORMATION

Billing contact (full name)

Business name

Business billing address (Not P.O. Box)

City

State

Zip Code

County

Email address

Phone number

SECTION B: ACH ACCOUNT INFORMATION

Initial premium amount

$

Account type

☐ Checking ☐ Savings

⑆123456789⑆ 000123456789⑇

9 DIGIT ROUTING NUMBER   YOUR ACCOUNT NUMBER

Bank name

Routing number

Account number

Confirmation account number

SECTION C: GENERAL AGREEMENT

I (we) hereby authorize Healthfirst Insurance Company, Inc. ("Healthfirst") to initiate entries to my (our) checking/savings accounts at The Financial Institution listed above, and, if necessary, initiate adjustments for any transactions credited/debited in error. Once ACH information is received, Healthfirst will charge the account and funds may be withdrawn prior to the effective date of coverage. This authorization is only for the initial payment associated with my coverage.

SIGN HERE

Signature of Applicant

Printed Name

Date

*This is for an initial payment and will be charged one-time.

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