Authorization Agreement for ACH Debit/Change Method of Premium Payment

To authorize a monthly ACH debit or to request a change in the method of premium payment, please indicate which billing method you are changing to and complete all applicable information. You will then need to sign, date and return this form to Mountain Health CO-OP (CO-OP). See the bottom of this form for details.

☐ **ACH / EFT Draft** **Member Name:** ____________________ **Member Number:** ____________________

Please note: Premiums are withdrawn on a date of your choice between the 18th-25th of the month, for the following month's premium.

Date: (please enter a day between the 18th-25th) ☐

Attach a voided check or savings account deposit slip to provide the banking information.

(Please do not attach a checking account deposit slip. These do not contain the correct information.)

Type of Banking Account: ☐ **Checking Account** ☐ **SavingsAccount**

Name of Bank or SavingsInstitution: 9- ____________________________________

Digit Routing Number: ____________________ **Account Number:** ____________________________________

Name that appears on the Account: ____________________ **Address on the Account:** ____________________

Relationship of Account Holder to the Primary Applicant: ☐ **Self** ☐ **Spouse** ☐ **Other** __________ **Note: Business bank accounts may not be accepted.**

Account Holder hereby authorizes the CO-OP to collect the total premium payment due, via automatic withdrawal from the account identified and provided herein or then current. By signing below, I authorize the CO-OP to initiate automatic withdrawal of applicable premium payments from the account listed above. I understand that it is my responsibility to notify The CO-OP if I change banks or account numbers. I further agree this authorization will remain in effect until I provide written notification terminating this service. This request must be received at least ten (10) business days prior to the next scheduled draft date.

Account Holder Signature: ______________________________ **Date:** ____________________

Account Holder Name (print): ______________________________ **Phone Number:** ____________________

Complete, sign, date and call Member Services at 1-855-447-2900 for fax info or mail the completed form to Mountain Health CO-OP Member Services, *P.O. Box 5358, Helena, MT 59604* or email completed form to memberservice@mhc.coop

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