# Ohio Chamber Health Benefit Program (Self Funded) Payment Authorization Form

## A. APPLICANT INFORMATION

Employer Name _____

## B. INITIAL METHOD OF PAYMENT

☐ Check Enclosed

☐ Electronic Funds Transfer (EFT) (Complete EFT Authorization below.)

## C. ONGOING METHOD OF PAYMENT

☐ Electronic Funds Transfer (EFT) (Complete EFT Authorization below.)

☐ Direct Bill – Monthly (Fees may apply)

## D. STATEMENT OF UNDERSTANDING

As a participant of Scheduled Direct Deposit, I agree to and/or understand all of the following on behalf of my business:

It may take up to one month to establish this process.

I authorize United HealthCare Services, Inc. to debit my business checking or savings account for the monthly payment for premium equivalent. I will ensure sufficient funds are in my business checking or savings account to cover my monthly payment. If the necessary funds are not on deposit in the account at the beginning of the month, my participation agreement with Ohio Chamber Health Benefit Program (Self Funded) may be subject to termination under the terms stated in the contracts. Also, I understand my business may be subject to additional service fees subsequent to the termination date as a result of insufficient funds.

I will promptly notify United HealthCare Services, Inc. of any change to my business checking or savings account. If a change occurs, it is my responsibility to provide United HealthCare Services, Inc. with the current information.

## E. ELECTRONIC FUNDS TRANSFER AUTHORIZATION Type of Account: ☐ Checking ☐ Savings

Account Holder's Name _____ Financial Institution _____
(As it appears on financial institution records.)

Routing/Transit Number (9 digits required) _____ Account Number _____

I (we) hereby authorize United HealthCare Services, Inc. to initiate debit entries to the account and the financial institution named above. In submitting this payment authorization with the application, I understand that the initial payment may be adjusted based on the applicant's medical history (or that of any dependent to be covered) and agree that the additional amount(s) required may be charged to this account. United HealthCare Services, Inc. will not be held responsible for a contract lapse or termination due to nonpayment if the withdrawal is presented and not honored for any reason and the amount due is not paid. United HealthCare Services, Inc. is not responsible for charges I may incur from my bank due to late notification of the termination or change. This authorization is to remain in full force and effect until United HealthCare Services, Inc. has received written notice of my intention to terminate this authorization. I understand that I must give at least 30 days' advance notice to terminate or change this authorization. If the automatic bank draft or direct payment by check transaction is returned for any reason, a $25 nonrefundable service fee will be applied.

Authorized or Account Holder Signature X_____ Date _____

Employer's Email Address _____