Automated Clearing House (ACH) Debit Authorization Form for Employer Groups

PLEASE NOTE: We must receive this form by the 15th of the month prior to the draft date. For example, if you want us to begin drafting your account on February 1, we must receive the form by January 15. If we receive this form after the 15th of the month, we cannot begin drafting your account until the first of the ***following*** month. All contents of this form are required. **Incomplete forms will not be processed and will be returned**.

I am an authorized representative of an Employer Group and am completing this form to make payment for that policy.

Name: ____ Group ID#: ___________________________________
Indicate name of Employer Group

Mailing Address: ____

Contact Name and Phone Number for Employer Groups: ____________________________________(____)_____________

Email Address: ____

I hereby authorize True Health New Mexico to initiate debit entries to the checking account indicated below and request the financial institution named below to debit the same to such account. This information will be kept for ongoing payments and the account listed will be drafted for the monthly premium amount. I am an authorized signor on the account indicated below:

Month to Begin Bank Draft from Checking Account: ____________________
Note: Account will be drafted on the **first** business day of the month.

Name of Financial Institution	Address of Financial Institution
Name of Checking Account/Name on Checking Account	
Financial Institution Transit Routing Number (9 digits – see diagram below)	Checking Account Number (see diagram below)

You must attach a voided check for financial institution and account information verification.

Name Check
Address
City, State, Zip

Pay to the order of:
Please attach an unsigned voided check here (if applicable)
Dollars
In the amount of:
Financial Institution Name
For:
|: 123456789 :| 00998765432

This is your bank's Transit Routing Number. This is your Account Number.

This authorization will remain in effect until True Health New Mexico has received written notification of its termination in such time and in such manner as to afford True Health New Mexico a reasonable opportunity to act on it.

Name: ____
(Please Print)

Signature: ____ Date: ______________________________________

Please mail this form to True Health New Mexico, Attn: Finance, P.O. Box 36719, Albuquerque, NM, 87176. Please attach a copy of a voided check.