ELECTRONIC FUND TRANSFER FORM

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

A. PERSONAL INFORMATION

Applicant's Last Name	First Name	MI	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. ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION

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 ____________