Automated Clearinghouse Transfer Authorization

Please read and complete this authorization agreement form in its entirety.

I authorize Fallon Health to automatically charge my account at the financial institution listed below for the purpose of collecting my first month's premium. I authorize this one-time automated clearinghouse withdrawal for the amount of $_____.

Please print clearly.

Member information

ID account # (Fallon to fill in): _____

Name (first and last): _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Please select one of the following:

❑ **Checking account** ❑ **Savings account** (must be a statement savings account)

For checking account withdrawals, please attach a voided check from your financial institution.

Name of financial institution: _____

Bank account number: _____

Routing number (9-digits): _____

(Obtain from your bank or on the bottom of your check.)

I authorize Fallon Health to automatically deduct the above amount from my account with the above financial institution. I understand that this agreement may be terminated by me or by Fallon at any time with a 30-day advance written notification. I have read and understand this form.

Signature: _____ Date: _____

(Bank account holder)

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