Employer EFT/ACH Form

You are authorizing HealthPass to make a deduction from your banking institution for your current cost of coverage. Please complete the form below and return it to HealthPass via fax or email.

Business Name: _____

Bank Name: _____

Bank Account Number: _____

ABA Number/Routing Number: _____

If using a savings account, contact bank for routing # which can also be found online by looking up bank name and location.

HealthPass Group #:_____

☐ Please check if you would like to enroll in paperless billing. If enrolling in paperless billing we must have an active email address on file.

Ongoing

Recurring EFT/ACH Authorization

☐ Please check if this is a recurring monthly payment.*

I hereby authorize HealthPass to initiate EFT/ACH from my account until further notice for the payment of my monthly cost of coverage. Withdrawals occur on or about the 1st of every month. Please call 888-313-7010 to notify us of any change in this request.

Begin my monthly EFT/ACH payments _____
Coverage Month

_____

Signature of Authorized Representative **Date**

One-Time

☐ Please check if this is a one-time only payment.*

Amount $_____

I hereby authorize HealthPass to immediately initiate this one-time EFT/ACH from my account for the payment of my monthly cost of coverage. Please call 888-313-7010 to notify us of any change in this request.

_____

Signature of Authorized Representative **Date**

*Our Merchant ID is 0000131575, your financial institution may need this ID in order for payments to be processed successfully.

HealthPass New York
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Billing: 888-313-7010
Fax: 212-252-7448
billing@healthpassny.com