Employer Electronic Fund Transfer Form

Return completed, signed form to: Aspirus Health Plan, ATTN: Finance, PO Box 1890 Southampton PA 18966
or email to: Finance@aspirushealthplan.com. If you have questions, please call Customer Service at: 866.631.5404

Authorization Agreement for Electronic Fund Transfers

Employer's Legal Name	Employer's Number

I hereby authorize the Insurer, hereinafter called COMPANY, to initiate, if necessary, debit entries and adjustments for any credit entries in error to my:

(Select one) ☐ Checking Account* ☐ Savings Account

indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

Depository Name		Branch	
Depository Address	City	State	Zip Code
Transit Number	Account Number		

This authority is to remain in force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

Employer Representative Signature _____ Date _____

Employer Representative Name _____ Title _____ Telephone Number _____ Fax Number _____

*IF USING A CHECKING ACCOUNT, PLEASE ATTACH A CHECK