

Individual & Family plan

Transfer of funds for monthly premium payment

Mail completed form to: Membership Accounts, P.O. Box 34750, Seattle, WA 98124-1750

I hereby authorize Group Health Cooperative or Group Health Options, Inc. to initiate fund transfers from my depository financial institution (bank) account indicated below and authorize my bank to honor these transfers.

Subscriber name		
Subscriber address		
City	State	ZIP
Subscriber number	Group number	
Bank name	Branch	
City	State	ZIP
Bank account number	Bank routing number	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Name(s) listed on account		

If you would like to cancel your transfer of funds please check this box and sign below.

Please attach a VOIDED CHECK or SAVINGS DEPOSIT SLIP here.

Payment will be deducted between the seventh and tenth day of each month for the current month's premium.

I agree to indemnify and hold harmless Group Health Cooperative or Group Health Options, Inc., their officers, directors, employees, and agents, for any claims arising out of transfers or deductions from my account in accordance with this agreement.

I have read and understand the terms and conditions printed on the back of this page.

Signed _____

Date _____

Signed _____

Date _____

Return this copy

Terms and conditions of agreement for automated payment plan

1. I understand that this agreement will remain in effect until Group Health* has received written notice from me that it should be cancelled. Notice of cancellation must be received by Group Health by the thirteenth day of the month to cancel this agreement effective the first day of the following month.
2. I further understand that I have the right to stop payment of a transfer from my depository financial institution (bank) account to Group Health. Notice of stop-payment to my bank must be made at least three working days before the seventh working day of the month. This notice will automatically cancel this agreement.
3. If no funds are transferred from my bank account to Group Health due to insufficient funds, I understand that to keep this agreement in force my account will be debited for the balance due, on or before the next automatic withdrawal date.
4. I understand the amount of transfer will change at the annual rate renewal, and that notice of this annual monthly dues change will be mailed to the address of record thirty days prior to its effective date.
5. I understand that I will not receive notice of change in the amount of a transfer, which may vary from the previous month due to the addition or deletion of persons enrolled under this agreement.
6. I understand that if I transfer my current enrollment to a Group Health Cooperative or Group Health Options, Inc. employer group, this agreement is automatically cancelled.
7. I understand that if I transfer my current enrollment to another Group Health individual plan, this agreement is automatically cancelled, and I will be required to complete another Individual & Family Plan Transfer of Funds for Monthly Premium Payment agreement.

*Group Health refers to Group Health Cooperative or Group Health Options, Inc.

Individual & Family plan

Transfer of funds for monthly premium payment

Mail completed form to: Membership Accounts, P.O. Box 34750, Seattle, WA 98124-1750

I hereby authorize Group Health Cooperative or Group Health Options, Inc. to initiate fund transfers from my depository financial institution (bank) account indicated below and authorize my bank to honor these transfers.

Subscriber name		
Subscriber address		
City	State	ZIP
Subscriber number	Group number	
Bank name	Branch	
City	State	ZIP
Bank account number	Bank routing number	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Name(s) listed on account		

If you would like to cancel your transfer of funds please check this box and sign below.

Please attach a VOIDED CHECK or SAVINGS DEPOSIT SLIP here.

Payment will be deducted between the seventh and tenth day of each month for the current month's premium.

I agree to indemnify and hold harmless Group Health Cooperative or Group Health Options, Inc., their officers, directors, employees, and agents, for any claims arising out of transfers or deductions from my account in accordance with this agreement.

I have read and understand the terms and conditions printed on the back of this page.

Signed _____

Date _____

Signed _____

Date _____

Keep this copy for your records.

Terms and conditions of agreement for automated payment plan

1. I understand that this agreement will remain in effect until Group Health* has received written notice from me that it should be cancelled. Notice of cancellation must be received by Group Health by the thirteenth day of the month to cancel this agreement effective the first day of the following month.
2. I further understand that I have the right to stop payment of a transfer from my depository financial institution (bank) account to Group Health. Notice of stop-payment to my bank must be made at least three working days before the seventh working day of the month. This notice will automatically cancel this agreement.
3. If no funds are transferred from my bank account to Group Health due to insufficient funds, I understand that to keep this agreement in force my account will be debited for the balance due, on or before the next automatic withdrawal date.
4. I understand the amount of transfer will change at the annual rate renewal, and that notice of this annual monthly dues change will be mailed to the address of record thirty days prior to its effective date.
5. I understand that I will not receive notice of change in the amount of a transfer, which may vary from the previous month due to the addition or deletion of persons enrolled under this agreement.
6. I understand that if I transfer my current enrollment to a Group Health Cooperative or Group Health Options, Inc. employer group, this agreement is automatically cancelled.
7. I understand that if I transfer my current enrollment to another Group Health individual plan, this agreement is automatically cancelled, and I will be required to complete another Individual & Family Plan Transfer of Funds for Monthly Premium Payment agreement.

*Group Health refers to Group Health Cooperative or Group Health Options, Inc.