

Individual and family plan Funds Transfer Agreement

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

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) or company listed on account		

Please attach a VOIDED CHECK or SAVINGS DEPOSIT SLIP here.

If you would like to authorize funds transfer, please read the following information, check this box, and sign below.

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

I/we hereby authorize Group Health Cooperative or Group Health Options, Inc. to initiate funds transfers from the depository financial institution (Bank) account indicated above and authorize Bank to honor these transfers.

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

I/we have read and agree to the terms and conditions printed on the back of this page.

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

Signed Date

Signed Date

Company contact Phone Date

Return this copy

Terms and conditions of Funds Transfer Agreement

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 to ensure stop-payment for that 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 that the amount of transfer will change at the health plan's annual rate renewal, and that notice of this change will be mailed to the subscriber address of record thirty days prior to its effective date.
 5. I understand that I will not receive notice of any change in the amount of a transfer, resulting from the addition or deletion of persons enrolled under the plan.
 6. I understand that if I transfer my current plan enrollment to a Group Health Cooperative or Group Health Options, Inc. employer group Plan, this Agreement is automatically cancelled.
- For premiums paid by employer:**
7. Individual and Family plan contracts are between Group Health and the Plan subscriber. When an employer makes payments on behalf of a subscriber, the employer agrees to indemnify and hold harmless Group Health against any claims arising from transfers or deductions from an employer's account.
 8. No overpayments will be reimbursed back to an employer since the Plan contract payment terms are between Group Health and the subscriber. Employers are responsible for obtaining reimbursement from Plan subscribers.

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Date _____

Signed _____

Date _____

Company contact _____

Phone _____

Date _____

Keep this copy for your records

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