Please return this form to:

Fallon Health
Billing Operations
10 Chestnut St.
Worcester, MA 01608

Fax: 1-508-831-1136

Automated Clearinghouse Transfer Authorization

Please read and complete this authorization agreement form in its entirety.
I authorize Fallon Health to automatically deduct from my account at the financial institution listed below for the purpose of collecting my premium and/or correcting an erroneous debit previously deducted from my account. Fallon can make adjustment entries, if necessary, only under the conditions described in this authorization agreement. I understand that this agreement may be terminated by me or by Fallon at any time by a 30-day advance written notification.

PLEASE PRINT CLEARLY
Customer information:

Customer number: _____ Phone: _____

Name: _____

Please select one of the following:

☐ **Checking account** (**Important:** Please attach a voided check to the form.)

☐ **Savings account** (Must be a statement savings account.)

Name of financial institution: _____

Bank account number: _____

ABA routing number: _____
(Obtain from your bank. This is a nine digit number that begins with a 0, 1, 2, or 3 only.)

☐ **One-time only payment** (Invoices will be mailed monthly.)

Amount authorized: $_____

☐ **Recurring monthly payment** (Payment will be deducted once a month for your monthly premium. **You will not receive a monthly invoice.**)

I authorize Fallon Health to automatically deduct my **total premium billed** from my account with the above financial institution. **I have read and understand this form.**

Signature: _____ Date: _____
(of bank account holder)

If you have questions regarding this form, please call us at 1-800-333-2535, ext. 69322 (TRS 711), Monday, Tuesday, Thursday, and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.

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New sales ACH form