Electronic Funds Transfer Agreement

Member name:	**Member ID:**
Account holder name(s):	
Bank name:	
Bank routing number (9 digits): ☐☐☐☐☐☐☐☐☐	**Bank account number:**
Account type: ❑ Checking ❑ Savings	

Important: Indiana University Health Plans will withdraw the premium on the 3rd day of each month.

Note: Electronic Funds Transfer may take two months to begin and in this case you will continue to receive a premium notice for the month(s) prior to the deduction start date.

I (we) hereby authorize Indiana University Health Plans to initiate debit entries to my (our) account indicated above.

This agreement is to remain in full force until Indiana University Health Plans have received written notification from me (us) of its termination.

Account holder signature:	
Account holder signature:	
Date:	**Daytime phone number:**

Please include a voided check from your checkbook or a voided pre-printed savings deposit slip.

Return this form and voided check/savings deposit slip to:

IU Health Plans
Attention: Premium Billing
950 N. Meridian St., Suite 400
Indianapolis, IN 46204-1202
F 317.968.1331

IU HEALTH Health Plans