QualChoice® HEALTH INSURANCE

Authorization for Automatic Payments — Group
ACH Debits

PLEASE PRINT

Section I. Group/Plan Sponsor Information		
Name of Group/Plan Sponsor	Name of Authorized Group Representative	Phone No.

Authorization for Automatic Payments

I authorize QualChoice to debit from our group bank account the amount necessary to pay the monthly premium owed under our group's QualChoice contract. This authority will remain in effect until I, or another authorized group representative, notifies QualChoice or the bank/financial institution listed below, in writing to cancel it in such time (30 days) as to afford the bank a reasonable opportunity to act on the cancellation.

Section II: Bank/Financial Institution Information			
Name of Bank/Financial Institution	City	State	Zip Code

Please deduct our group's monthly premium from *(check one)*: ☐ Checking ☐ Savings

Account Number: _____ 9 Digit Routing Number: _____

Signature of Authorized Group Representative — Date (MM/DD/YYYY)

X

Section III: Account Holder Information
Print Name of Authorized Account Holder
Signature of Authorized Account Holder — Date (MM/DD/YYYY)

Section IV: Instructions

Mail:
QualChoice
ATTN: Finance Dept.
P.O.Box 25610
Little Rock, AR 72221

Fax: 833.681.2496

Email: qca_finance@qualchoice.com

If you have any questions, or if there is a change in your banking information, please call:
QualChoice Finance Department
501.228.7111 or 800.235.7111
Monday-Friday, 8:00 a.m. to 5:00 p.m., Central Time