



## **Electronic Funds Transfer (EFT) Agreement Form**

Arranging convenient, automatic plan premium payments from your bank\* account can be done in **three easy steps:**

- 1) Read this Electronic Funds Transfer (EFT) Agreement Form.
- 2) Complete this form.
- 3) Return your completed form and a voided check (if deductions are transferred from a checking account) or a deposit slip (if deductions are coming from a savings account) to the following address:

**Care Improvement Plus  
Attn: Premium Billing Department  
351 W. Camden Street, Suite 100  
Baltimore, MD 21201**

### **Electronic Funds Transfer (EFT) Plan Premium Payment Option**

Care Improvement Plus encourages you to pay your monthly plan premium using Electronic Funds Transfer (EFT). Your monthly plan premium will be electronically transferred from your bank account to Care Improvement Plus, saving you both time and money. There is no trip to the post office, no check to write, and no stamps to buy.

EFT is a simple and convenient way for you to pay your monthly plan premium and ensures timely payments, which will prevent a possible lapse in coverage. In addition, your payments are taken care of even if you're out of town.

### **Choosing the EFT Plan Premium Payment Option**

To have your Care Improvement Plus monthly plan premium paid through EFT, complete, sign, and return this EFT Agreement Form. Be sure to include a voided check (if deductions are transferred from a checking account) or a deposit slip (if deductions are coming from a savings account) that contains your bank account and routing number. Once this EFT form is processed by Care Improvement Plus, your payments will be deducted from your account on or between the 5<sup>th</sup> – 7<sup>th</sup> of each month. Note, EFT may take two to three months to begin and the first deduction will also include any outstanding balance on your account.

For more information about our EFT plan premium payment option, please call 1-800-204-1002 (TTY: 1-800-713-1603), 7-days-a-week, 8:00 am - 8:00 pm.

\* As used herein, the term "bank" on this form includes all types of depository financial institutions.

# EFT Agreement

I hereby authorize Care Improvement Plus to initiate funds transfers to pay my monthly plan premium from my bank\* account indicated below, and authorize my bank to honor these transfers.

## Applicant/Member Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Member ID (if applicable) \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone Number \_\_\_\_\_

## Bank Account Holder Information (if different from Applicant/Member information)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Name of Bank \_\_\_\_\_  
(Please print as it appears on the bank account)

Bank Routing Number \_\_\_\_\_ Bank Account Number \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Branch \_\_\_\_\_ Branch Phone Number \_\_\_\_\_

## Account funds to be transferred from (please check only one):

- Checking** (For EFT withdrawals from your checking account, simply attach a voided check.)
- Savings** (For EFT withdraws from your savings account, simply attach a deposit slip that includes your account number and routing number.)

I understand it may take two to three months for Electronic Funds Transfer (EFT) to begin and that the transfer of funds will occur between the 5th – 7th of each month. I understand the first deduction will also include any outstanding balance on my account from the effective date of my enrollment or effective date of the change to EFT. I understand I have the right to stop payment of a transfer from my bank account to Care Improvement Plus and that I must notify my bank at least 3 days before the scheduled payment date.

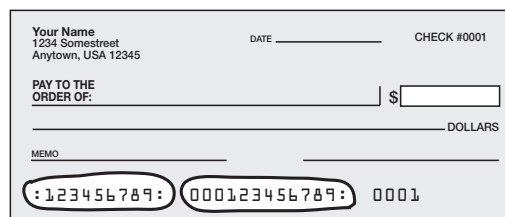
If a beneficiary decides to switch to EFT or move from EFT to direct bill, it could take up to three months for it to take effect and they will ultimately be held responsible for those premiums.

I agree to indemnify and hold harmless Care Improvement Plus for any claims arising out of transfers or deductions from my account pursuant to this agreement. I understand that this agreement will remain in effect until Care Improvement Plus has received written notice from me that it should be cancelled. This notice shall be given no less than 30 days before the next scheduled payment.

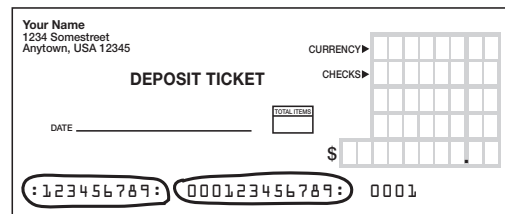
Applicant/Member Signature \_\_\_\_\_ Date \_\_\_\_\_

Account Holder's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Bank routing number      Bank account number



Bank routing number      Bank account number