COMMON GROUND
HEALTHCARE COOPERATIVE

# Employer

## Electronic Funds Transfer Authorization- Monthly Deductions

Common Ground Healthcare Cooperative accepts monthly premium payments via Electronic Funds Transfer (EFT). PLEASE NOTE: Your first month's premium payment cannot be paid via EFT by using this form. It can only be paid via EFT if you perform this action online.

**To Begin Automatic Withdrawal of Funds from your Bank Account**:

1. Complete the information below
2. Sign and date
3. Attach a voided check, if you will be paying via your checking account
4. Mail to: Common Ground Healthcare Cooperative (CGHC)
   ATTN: Group Services
   120 Bishop's Way, Suite 150
   Brookfield, WI 53005

**Please complete the following information to have your premium payment paid via EFT. Your payment will be requested on the 25th of each month or the next business day prior to coverage. Please allow up to three (3) business days for processing.**

| **Please PRINT:** | | |
|---|---|---|
| **Employer Name:** | **Group Number:** | **1st Payment to Begin EFT Process:**<br>**25th of _____**<br>**(specify month)** |
| **Daytime Telephone Number:** | **Email Address:** | |
| **Name of Financial Institution:** | **Account Name:** | **Type of Account:** **Checking** ☐<br>**Savings** ☐ |

**Routing Number** | | | | | | | | | |

*The first nine (9) digits found at the bottom of your check; Savings customers: ask your financial institution*

**Account Number** | | | | | | | | | | | | | | | | | |

*The number found after the routing number at the bottom of your check; OR check your bank statement*

I hereby authorize Common Ground Healthcare Cooperative to instruct my financial institution to deduct monthly premium payments from the account listed above, for the benefit of the employer listed above. I understand that these deductions will continue for the term of the policy, or until Common Ground Healthcare Cooperative has received notification from an authorized employer representative to discontinue the withdrawals.

Authorized Representative Signature _____ Title of Representative _____ Date _____