



Health Plans

Direct Deposit Authorization Form

Employer Name _____

Employee Name: _____ Employee SSN: _____

Type of Transaction: New Change Cancel

****Please note that before the ACH option takes effect a pre-notification(pre-note) transaction needs to be sent to the bank for approval, therefore the next disbursement after this election will still come in the form of a "live" check. The remaining payments will be via ACH. Any ACH transactions stopped by the bank will cancel your ACH election until corrections can be made.**

I hereby authorize IU Health Plans to initiate credit entries to my: Checking Account Savings Account

****An actual voided check must be attached****
Staple voided check here

This form will not be processed without a voided check

Memo: _____

|'074902341|: 1234567899|'|

Routing Number	Bank Account
(9 Digits)	Number

Bank Account Number: _____
(see illustration above)

Name of Financial Institution: _____ Branch: _____

City: _____ State: _____ Zip: _____

Bank ACH Transit Routing Number: _____
(see illustration above)

This authorization will remain in force from one plan year to the next and stay in effective until IU Health Plans has received written notification of its cancellation. IU Health Plans is not responsible for any bank fees related to expenditures made before an actual ACH deposit is in your account. It is your responsibility to verify that the funds are in your account before you use them.

Signature: _____ Date _____

If this is a new enrollment, return with enrollment form. Otherwise mail or fax to: IU Health Plans, P.O. Box 628, Columbus, IN 47202. Fax 800-391-3539