LIA Health Alliance℠
New York's Health Insurance Exchange℠

Electronic Debiting Form

The Alliance utilizes electronic funds transfer to simplify health insurance administration and reduce costs for small businesses. Electronic Debiting is the simplest and most worry-free way to pay your monthly health insurance bills. Some of the advantages of Electronic Debiting include:

✓ Worry-free payment. ✓ No check writing. ✓ Automated record keeping.

Worry-free payment: You never have to worry if a bill has been lost or misplaced. As long as sufficient funds are in your bank account, you will always pay on a timely basis.

No check writing: Electronic Debiting authorizes payment to be transferred electronically from your bank account with little or no administrative effort.

Automated record keeping: When funds are debited from your bank account, you will receive a detailed description of all transactions on your bank statement. It will detail the amount and date of the electronic payment transfer and the authorized party who initiated the transaction.

How It Works

The LIA Health Alliance will process payment transactions electronically with the Bank that you designate. With electronic debiting, monthly billed amounts are transferred electronically and your bill is "paid" timely and accurately.

Please take a moment to complete the information requested on the reverse side and return this form with your enrollment materials.

If you have any questions, please call the LIAHA Enrollment Processing Center at

1-800-542-5513

Please provide the Alliance with the following bank account information. Monthly billed amounts will be electronically transferred from the Bank that you designate below. Please attach a voided check to identify the designated Bank and the account you want debited.

PLEASE PRINT CLEARLY

Designated Bank Name:_____

Address: _____
Street Suite #

_____
City State ZIP

Designated Bank Tel. #: (____) _____

Account Number: _____

Name(s) on the Account: _____

Company Name:_____

Company Address: _____
Street Suite #

_____
City State ZIP

Company Telephone Number: (____) _____

Company Fax Number: (____) _____

COMPANY E-MAIL:

I authorize the Alliance, or its administrative agent, to transfer funds from the account identified above. The purpose of the transfer is to pay monthly health insurance bills for the above listed company. I understand that the funds will be requested from the Bank that I designate on or about the last business day of every month. I authorize monthly billed amounts for health insurance to be debited from the account listed above and transferred into the LIA Health Alliance Enrollment Processing bank account within twenty-four hours of the request.

Name/Title: _____Date: _____

Signature: _____
Authorized Company Representative