700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
uhahealth.com

AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (EFT)
EMPLOYER GROUP / COBRA MEMBER FORM

Please check the box that best describes you: ☐ **Employer Group** **Group #:** _____

☐ **COBRA Member** **Member ID#:**_____

COMPANY OR MEMBER INFORMATION (ALL FIELDS MUST BE COMPLETED):

GROUP NAME OR MEMBER NAME: _____

Checking account holder, please sign below:
I authorize UHA and the bank shown below to begin electronic credit and/or debt entries to my (our) account. I also acknowledge that by signing below, if I decide to terminate coverage, I am responsible to notify UHA by the 25th of the respective month of termination. In a situation where UHA is not notified by the 25th of the month of termination, I acknowledge that funds may still be pulled from my account and UHA will provide a refund up to two weeks after the funds are deducted.

Print Name _____ Job Title _____ Signature _____ Date _____

BANK INFORMATION: (CHECKING ACCOUNTS ONLY – SAVINGS ACCOUNTS ARE NOT ELIGIBLE)

ATTACH A COPY OF A VOIDED CHECK IN THIS BOX

IF A VOIDED CHECK IS NOT AVAILABLE PLEASE ATTACH A COPY OF A LETTER FROM

YOUR FINANCIAL INSTITUTION ON THEIR LETTERHEAD

CERTIFING YOUR CHECKING ACCOUNT NUMBER AND ROUTING NUMBER

IMPORTANT INFORMATION

TERMS OF AGREEMENT: Electronic bank deposit entries shall be initiated by UHA to pay for authorized products and services and the entries shall constitute my receipt for the transaction(s). I understand that if corrections of the entry are necessary, it may involve an adjustment to my account. I also understand that any direct electronic receipt will be credited and that this process could take up to 60 days before completing this transaction.

I will be responsible for all electronic funds transfer charges required by my financial institution.

NOTE: UHA reserves the right to refuse or terminate electronic payment and/or collection services. This agreement is to remain in effect until UHA terminates it or receives written notification of its termination and has sufficient time to act on it.

INSTRUCTIONS:
1) Keep a copy of the completed form for your records.
2) Send this form and attach a voided check (deposit slips are NOT acceptable) in the provided space above, or a signed confirmation letter in lieu of a check from your financial institution to: Employer Services Department, UHA, 700 Bishop Street, Suite 300, Honolulu, HI 96813 or contact your Client Services representative for more information.

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FOR OFFICE USE ONLY

Has the group/COBRA member been called directly via the phone number on file to confirm the form origination? ☐Yes ☐No
Has there been a change in contact information within the last two months? ☐Yes ☐No
If so, describe the actions taken to verify the authenticity of the request_____

_____

Is there a complete group number? ☐Yes ☐No
Is the form signed? ☐Yes ☐No
Is the copy of the check clear and legible? ☐Yes ☐No

Reviewer: _____