MERITAIN HEALTH
An Aetna Company

Authorization for ACH Transfer

Please Print or Type

Group/Employer Name	Group #	Address	Telephone #

Please allow 2-3 weeks for direct withdrawal to take effect.

Action (Check one): ☐ Enroll ☐ Change ☐ Cancel

1. I hereby authorize Meritain Health, 300 Corporate Parkway, Amherst, NY 14226, hereinafter called COMPANY, to initiate debit entries from my account indicated below and the depository name, hereinafter called DEPOSITORY, to debit the same account.

2. Withdrawal from the following account:
   ☐ Checking Account ☐ Savings Account

3. I understand that Meritain pulls funds from ACH accounts the last Friday of the month prior to the month in which invoices are due. I elect to have my funds pulled on the:

   ■ Last Friday of prior month in which funds are due for my invoice

Depository Bank Name

Bank Routing Number Account Number

4. I agree to allow the COMPANY to stop payment or posting of, reverse, or adjust any entry erroneously debited or credited to my account.

5. This authorization is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and manner as to afford the COMPANY a reasonable opportunity to act on it.

Print Name Title (if applicable) Date

Signature

Mail this form with attached documents to: **MERITAIN HEALTH, ATTN: ACCOUNTS RECEIVABLE, PO BOX 1652, AMHERST, NY 14226.**
EMAIL: ACCOUNTSRECEIVABLE@MERITAIN.COM

Below is the necessary information that may be required to authorize MERITAIN HEALTH to debit your source bank account:

ABA 04300026 **ACH company ID** 9000002010

Contact Accounts Receivable with any questions regarding ACH at (716) 319-5156

Please Attach Your Voided Check Here
(Scanned images of the check are also acceptable)