GROUP INFORMATION

GROUP NAME ____

GROUP ADDRESS ____

____

______________________ City ______ State ________-______ ZIP Code

CONTACT PERSON ______________________TELEPHONE # (____) ______-__________

PAYMENT OPTIONS – CHOOSE ONE

☐ **OPTION 1 DIRECT DEBIT**

ROUTING NUMBER |__|__|__|__|__|__|__|__|__|

FINANCIAL INSTITUTION____

NAME ON ACCOUNT ____

ACCOUNT NUMBER |__|__|__|__|__|__|__|__|__|__|__| ☐ Checking ☐ Savings

(Check one)

Note: Because of processing time (30 days) 1st payment must be made by check

☐ **OPTION 2 CREDIT CARD**

( ) VISA or ( ) MASTERCARD

NAME ON CARD____

CARD NUMBER______________________________ EXPIRATION DATE_____ _____

I authorize Healthplex to either debit the above-referenced account ***or*** charge the above referenced credit card for my premium due. I understand that payment will be made by the 1st business day of each billing cycle.

☐ Monthly ☐ Semi-Annual

☐ Quarterly ☐ Annual IN THE AMOUNT OF $__________.______

AUTHORIZED SIGNATURE____

PLEASE PRINT NAME____

TITLE______________________________ DATE______________________

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