Employer Electronic Funds Transfer (EFT) Form

EMPLOYER INFORMATION			
Employer/Business Name		Federal Tax ID	
Name of Company Owner(s) (Last, First, MI)		Additional Names on Employer Account (Last, First, MI)	
Address	City	State	Zip
Phone Number:		Email address:	

BANKING INFORMATION

Indicate type of account (Circle One): Checking Savings Other

ROUTING NUMBER **ACCOUNT NUMBER**

Tape a non-returnable, voided check or legible copy of a voided check or deposit slip to this document in the area above. The voided check or image must have routing number and account number for proper crediting of your account.

AUTHORIZATION

By my signature below I certify I represent the Employer and all Employer account holders and I authorize TexHealth Central Texas to deposit into the Employer's account, represented above by the voided check or voided check image, funds to pay for the employees' shares of the health insurance premiums.

I understand that:

1. There is a 3 month qualifying period between when an employee becomes eligible for premium assistance and when it is deposited.
2. The amount of the EFT may vary from month-to-month depending on number of employees enrolled, insurance premium, etc.
3. Additions and terminations of employees will be included in the EFT in the appropriate month following the 90 day qualifying period.
4. Notification of an enrolled employee's termination of employment must be received in writing by TexHealth Central Texas no later than the end of termination month.
5. Notification of employer group termination (due to the business closing or moving out of the county) must be received in writing by TexHealth Central Texas no later than the end of the termination month.
6. Employer understands and agrees that overpayments may occur and will be deducted from future payments.
7. Failure to remit premium assistance to employees when due may result in termination of the TexHealth Central Texas Plan and legal proceedings to recover payments may be initiated.
8. Other applicable terms and conditions are set forth in the Employer Enrollment Agreement between the Employer and TexHealth Central Texas.

Authorized Account Holder Signature ______________________ Date signed ____________

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