Automated Clearing House (ACH) Authorization

In accordance with my election of coverage under WellSense Health Plan, I hereby authorize WellSense to initiate debit entries and adjustments for any debit entries in error to my checking or savings account indicated below and the depository named below, to credit and/or the debit the same to such account. This authorizes debits and credits from my account indicated below only to the extent necessary to pay the required premiums for participation in WellSense.

Financial Institution: (Bank or credit union)

☐ Checking (Please attach a voided check)

☐ Savings (Please attach a deposit slip)

____
Name of Financial Institution

____
Address

City	State	Zip

____
Account Number

____
ABA Routing Number: (For both checking and savings accounts, this number can be obtained from your financial institution. For checking accounts, this number can be obtained from the bottom left side of the check. For either account, please do not use any numbers from deposit slips.)

____
Name on Account

This authority is to remain in full force and in effect until WellSense has received notification from me of its termination at such time and in such manner as to afford WellSense and my financial institution a reasonable opportunity to act on it.

Date	Name (Please print)	Signature

Please mail completed form to:

WellSense Health Plan
PO Box 106101
Jefferson City, MO 65110-9808