

THIS FORM IS TO BE USED <u>ONLY</u> FOR THOSE NH MEMBERS WHO ENROLLED THROUGH THE <u>FEDERALLY FACILITATED MARKETPLACE</u>

Authorization for Electronic Payments (EFT) Form

Section I.

This EFT authorization form is intended for the initial and/or ongoing premium payments. Please indicate if this request applies to the initial premium payment, ongoing premium payments or both in the appropriate check box below in Section II.

In the event that this request is for the initial payment only, the EFT for all future/ongoing payments, must be established by accessing Minuteman's secure member portal at **www.minutemanhealthdirect.org**. You may do this once you receive your Member ID card. All requests to cancel recurring EFT payments must be made through Minuteman's secure member portal.

Instructions: Please complete this form below and fax it to 855-628-5048 or email it to eftpayments@minutemanhealth.org. Please make sure you include a VOIDED check. If your account does not issue checks, please indicate in Section II below. If you have any questions, please contact a Billing and Payment Specialist at 603-657-1027.

NOTE: ALL WRITTEN DEBIT AUTHORIZATIONS MUST PROVIDE THAT YOU MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING MINUTEMAN HEALTH IN THE MANNER SPECIFIED IN THIS AUTHORIZATION.

Client Name:		
FFM Application ID*:		
Mailing Address:		
City:	State:	Zip Code:
Phone Number:		
Section II.		
		ayment amount: \$
□Initial/Binder** Payment O	nly □ Monthly*** Paym	ment Only Initial and Monthly Payment
Type of Account:	☐ Checking	or ☐ Savings
Does this account issue che	_	C
Does this account issue the	CKS: L Yes L INO	
Name(s) on Account:		
		ames that appear on the account
Account Number <u>ı:</u>		
Name of Financial Instituti	on:	
City:		
Routing/Transit		



<u>IMPORTANT</u>: It is the responsibility of the person identified in Section I to ensure that the information provided on this form is complete and accurate. Minuteman Health will not be responsible and shall be held harmless for errors made in EFT payments that are a result of inaccurate or incomplete information provided on this form. In no event and under no circumstances will Minuteman Health's liability exceed the amount of the EFT payments in question. If there is more than one account holder on the account, both account holders will need to sign below.

By signing below, you hereby authorize Minuteman Health to initiate debit entries from the account listed in Section II and acknowledge and understand that you may incur a service charge for any EFT that is not honored. Minuteman Health requires an actual signature on this form from the authorized account owner(s), typed in name(s) in the signature field will not be accepted.

Signature of Account Owner	Date	Print Name
Signature of Account Owner (if more than one)	Date	Print Name

^{*}Please write your FFM Application ID on this line. If you do not know your FFM Application ID, you will need to log-in to your account on healthcare.gov and obtain the Application ID. Minuteman Health will NOT be able to process your EFT payment without either this information OR the Customer Account #.

^{**} The initial/binder payment will be withdrawn from your designated account within two business days of Minuteman's receipt of this properly completed form.

^{***}Monthly payments will be withdrawn from your designated account on the 18th of each month, effective for the following month. For example, a payment withdrawn on March 18th is for your April 1st premium payment.