





**IMPORTANT:** 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                      Date                      Print Name  
(if more than one)

\*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](http://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\*\* The initial/binder payment will be withdrawn from your designated account within two business days of Minuteman's receipt of this properly completed form.

\*\*\*Monthly payments will be withdrawn from your designated account on the 18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 For example, a payment withdrawn on March 18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