American Postal Workers Union Health Plan

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

- ☐ New EFT Enrollment
- ☐ Change to Current EFT Enrollment
  (e.g. account or bank changes)
- ☐ Cancel EFT Enrollment
- ☐ Check here if EFT payment is being made to the Home Office of Chain
  (Attach letter Authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

- ☐ Change of Ownership, and/or
- ☐ Change of Practice Location?

If you checked either a change of ownership or change of practice location above, you must submit a change of information prior to or accompanying this EFT authorization agreement submission.

PART II: ACCOUNT HOLDER INFORMATION

Provider/Supplier/Biller Legal Business Name		
Chain Organization Name or Home Office Legal Business Name *(if different from Chain Organization Name)* Account		
Holder's Practice Location Street Address		
Account Holder's Practice Location City	Account Holder's Practice Location State	Account Holder's Practice Location Zip Code

Tax Identification Number (designate ☐ SSN or ☐ EIN)

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National Provider Identifier (NPI) ☐☐☐☐☐☐☐☐☐☐

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PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution's Name		
Financial Institution's Street Address		
Financial Institution's City/Town	Financial Institution's State/Province	Financial Institution's Zip/Postal Code
Financial Institution's Telephone Number	Financial Institution's Contact Person	

Financial Institution Routing Number

☐☐☐☐☐☐☐☐☐

Provider's/Supplier's/IPP Entity's Account Number with Financial Institution	Type of Account *(check one)*
☐☐☐☐☐☐☐☐☐☐☐☐☐	☐ Checking Account ☐ Savings Account

PLEASE NOTE: In accordance with section 1104 of the Affordable Care Act, enrollment of electronic fund transfer (EFT) is for electronic fund transfer authorization only.

PART IV: CONTACT PERSON

Contact Person's Name	Contact Person's Title
Contact Person's Telephone Number	Contact Person's E-mail Address

PART V: AUTHORIZATION

I hereby authorize APWU Health Plan to initiate credit entries, to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. APWU Health Plan may assign its rights and obligations under this agreement to APWU Health Plans' designated fee-for-service contractor. APWU Health Plan may change its designated contractor at APWU Health Plans' discretion.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier entity, the said Provider/Supplier entity certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider/Supplier entity are in accordance with all applicable regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until APWU Health Plan has received written notification from me of its termination in such time and such manner as to afford APWU Health Plan and the Financial Institution a reasonable opportunity to act on it. APWU Health Plan will continue to send the direct deposit to the Financial Institution indicated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to APWU Health Plan an updated EFT Authorization Agreement.

SIGNATURE LINE

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Authorized/Delegated Official Title	Authorized/Delegated Official E-mail Address
Authorized/Delegated Official Signature *(Note: Must be original signature in black or blue ink.)*	Date

Please return this completed EFT authorization agreement to the following:

APWU Health Plan
Attention: Provider File Unit - Supervisor
P.O. Box 1358
Glen Burnie, MD 21060

PLEASE REMEMBER TO INCLUDE:

- **Completed EFT application with original signature.**
- **Voided check which matches name/account information on the EFT application.**
- **IRS Form W9 (only if payment has never been received from the APWU Health Plan).**

NOTE: Any missing or invalid information will delay the processing of your EFT application.