# EMPLOYER ELECTRONIC FUNDS TRANSFER FORM

This form authorizes Access Health CT Small Business to automatically deduct payment for the monthly premium from a business checking account.

1. Complete this Authorization Form
2. Attach a voided check – Not a deposit slip
3. Submit completed form and voided check to the address below

**Please read and sign before completing and submitting**

I hereby authorize Access Health CT Small Business to withdraw payment of my monthly premium from my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to allow and to debit any debit entries indicated by Access Health CT Small Business to my account. This authorization is to remain in full force and effect until Access Health CT Small Business and Bank have received written notice from me of its termination in such time and in such manner as to afford Access Health CT Small Business and Bank reasonable opportunity to act on it.

Business Name (as it appears on checking account): ______________________________

Bank Name: ______________________ Bank Telephone: ______________________

Bank Routing Number: ______________________ Bank Checking Account Number: ______________________

Access Health CT Small Business ID#: ______________________

**One Time**

☐ Check if this is a **one-time** only payment

**One Time EFT Authorization**

I hereby authorize Access Health CT Small Business to immediately initiate this one-time EFT from my account for payment of the monthly premium. Call 855-762-4928 to notify us of any change to this request.

Authorized Signature: ______________________ Date ______/______/______
Month / Day / Year

**Recurring**

☐ Check if this is a **recurring** monthly payment

**Recurring EFT Authorization**

I hereby authorize Access Health CT Small Business to initiate EFT from my account until further notice for payment of the monthly premium. Withdrawals will occur on or about the 1st of every month. Call 855-762-4928 to notify us of any change to this request.

**Begin my monthly EFT payments:** ______________________
Coverage Month

Authorized Signature: ______________________ Date ______/______/______
Month / Day / Year

*Return via mail to:*
Access Health CT Small Business
280 Trumbull Street, 15th Floor
Hartford, CT 06103

*Return via email to:*
SHOP.AHCT@ct.gov

*Return via fax to:* (860) 757-5330

**For Internal Use Only**

**Initials:** ____________

**Date:** ____________

**Time:** ____________

For Access Health CT Small Business Privacy Policy, go to www.SHOP.AHCT@ct.gov