



**NEW GROUP INITIAL ONE-TIME BINDER PAYMENT  
eCheck/ACH Authorization Form**

This form provides authorization to draft Company's initial one-time binder payment for new group premium.

**PLEASE FILL OUT THE INFORMATION BELOW  
to have an eCheck withdrawal for company's initial one-time binder payment.**

.....  
Company Name \_\_\_\_\_  
Billing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_  
.....

**BINDER PREMIUM INFORMATION**

Initial One-Time Binder Payment Amount \$ \_\_\_\_\_  
.....

**BANK ACCOUNT TYPE** – CHECK ONE  **Checking**  **Savings**

Name on Account \_\_\_\_\_  
Routing Number \_\_\_\_\_  
Account Number \_\_\_\_\_  
.....

**Authorization Agreement:** *By signing below, I confirm that I am an authorized representative and signatory of the above Company and hereby authorize Hometown Health to withdraw the **INITIAL ONE-TIME BINDER PAYMENT** from Company's bank account. I understand that this **INITIAL ONE-TIME BINDER PAYMENT** will be deducted from Company's account within one (1) to two (2) days after notification of Hometown Health's approval of Company's enrollment in a Hometown Health plan.*

Name (PRINTED) \_\_\_\_\_ Company Title \_\_\_\_\_

Company's Authorized Representative Signature \_\_\_\_\_ Date \_\_\_\_\_  
.....

**FOR INTERNAL USE ONLY**

Date funds withdrawn \_\_\_\_\_ Initials \_\_\_\_\_ Confirmation/Transaction# \_\_\_\_\_ (ATTACH RECEIPTS)

**AMOUNT**

EPO \$ \_\_\_\_\_ Invoice# \_\_\_\_\_  
HMO\$ \_\_\_\_\_ Invoice# \_\_\_\_\_  
PPO \$ \_\_\_\_\_ Invoice# \_\_\_\_\_  
.....