

## Neighborhood Health Partnership Scheduled Direct Debit

**Sign up for Neighborhood Health Partnership's Scheduled Direct Debit and have your premium payments automatically deducted from your bank account.**

If you're looking for new and better ways to help organize, streamline and generally make your job easier, there's no better place to start than with Neighborhood Health Partnership's Scheduled Direct Debit.

That's because Scheduled Direct Debit is a safe, convenient and automatic way to pay your monthly insurance premiums.

All you do is sign up, then every month we automatically deduct your premium from your company's bank account.

Even better, Scheduled Direct Debit helps you better organize your payment records, streamlines your monthly invoice payment process and frees you up to get on with the business of your business.

**Enroll today in Neighborhood Health Partnership's Scheduled Direct Debit program. Just fill in the simple form on the reverse side and return it to us. Do it today and give yourself one less thing to worry about.**

### **Scheduled Direct Debit:**

- ▶ Lets you pay your premium at the same time each month.
- ▶ Provides predictable cash outflow.
- ▶ Gives you a consistent process for your premium payment.
- ▶ Provides an accurate record of your payment listed right on your bank statement.
- ▶ Means you'll never have to worry about missing an invoice or a deadline again. Everything's taken care of automatically.

*Get organized.*

*Get streamlined.*

*Get Neighborhood Health Partnership's  
Scheduled Direct Debit.*

# Scheduled Direct Debit Authorization Form

## Enrollment instructions

1. Complete the form below.
2. List all customer numbers and bill groups that you wish to have paid by automatic withdrawal.
3. Fax this form to the fax number on the bottom of the authorization form.

**IMPORTANT: Please return the completed form along with a voided check (no deposit slips please.)**

## Statement of understanding

By executing this document in the space provided below, I hereby confirm that I am authorized to act on behalf of the employer/customer ("Group") described below and agree on behalf of Group to the following terms and conditions:

- Group authorizes Neighborhood Health Partnership to debit the group checking (account # provided below) for all monthly charges for coverage.
- Group understands that it may take up to one month to set up Scheduled Direct Debit and consequently all overdue premiums should be promptly paid in order to avoid receiving a delinquency letter and possible termination of your account during this initial set up period.
- Group understands and agrees that it will have sufficient funds in its account to cover the full premium invoice on the draft due date. If necessary funds are not in your account on the draft due date, group coverage may be subject to termination proceedings consistent with the terms stated in your Neighborhood Health Partnership contract.
- Group agrees to promptly notify Neighborhood Health Partnership of any change to the information provided.

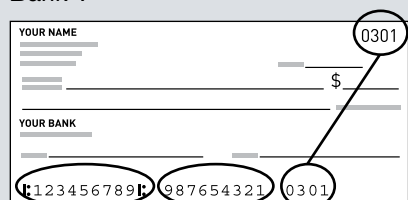
## Authorization

Authorization is given to Neighborhood Health Partnership to initiate debits (payments) to the financial institution indicated below. This financial institution is authorized to debit the account. This authority is to remain in full force and effect until either a 30 day revocation notice is written to Neighborhood Health Partnership; it is cancelled by Neighborhood Health Partnership under the conditions stated above; or upon termination of coverage with Neighborhood Health Partnership.

## Determining your routing number

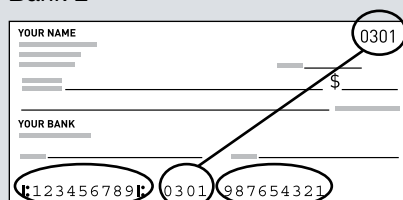
To determine your routing number, refer to your company check. **The routing number is always 9 digits long** and it is enclosed by colons. The location of the routing number and account number on your company check varies depending on your bank. For example:

Bank 1



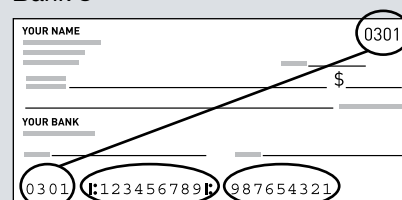
Routing # Account # Check #

Bank 2



Routing # Check # Account #

Bank 3



Check # Routing # Account #

If you are unsure what the routing number/transit number is, your bank can assist you.

**I have read and agree to the terms and conditions outlined above.**

\_\_\_\_\_  
Authorized signature and title of signatory

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer name/Customer name/Policy name

\_\_\_\_\_  
Employer email address

\_\_\_\_\_  
Neighborhood Health Partnership customer number and bill group(s)

\_\_\_\_\_  
Name of your financial institution

\_\_\_\_\_  
Telephone number of financial institution

Routing/Transit Number (9 Digits) 	Account Number (include all zeroes and omit spaces/special characters) 
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**Mail to:** Neighborhood Health Partnership, Inc.  
Attn: Billing Department  
IL008-1000  
1300 River Drive, Suite 200  
Moline, IL 61265

**OR**

**Fax to: 1-866-726-9610**  
Attn: Billing Department