



## AUTOMATIC PAYMENT SYSTEM (APS) AUTHORIZATION AGREEMENT

FirstCare Health Plans is hereby authorized to initiate debit entries to

\_\_\_\_\_ (**Group Name**) checking account indicated below for the total billed amount due. The account will be drafted no later than the 9<sup>th</sup> business day of each month. The Financial Institution named below, hereinafter called **BANK**, is hereby authorized to debit the same to such account.

**BANK NAME** \_\_\_\_\_ **BRANCH** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**ACCOUNT NUMBER** \_\_\_\_\_

Check here if this is a change in bank information.

This authority is to remain in full force and effect until FirstCare Health Plans has received written notification from the group of its termination in such time and in such manner as to afford FirstCare Health Plans a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notification to **BANK** prior to charging account. After account has been charged, a customer has the right to have the amount of an erroneous debit immediately credited to his account by **BANK**, up to 15 days following issuance of statement of account, or 45 days after the charge whichever occurs first.

**DATE** \_\_\_\_\_ **PHONE NUMBER** \_\_\_\_\_

**GROUP NAME & NUMBER** \_\_\_\_\_

**AUTHORIZED SIGNATURE** \_\_\_\_\_

**\*\*PLEASE ATTACH VOIDED COPY OF CHECK\*\***