Automated Clearing House (ACH) New Business Request

A. Business Information

Business Name

B. Contact Information

1. Contact Name		2. Daytime Telephone Number (include hyphens)	
3. Contact Address			
4. City	5. State/Province	6. Zip/Postal Code	7. Country
8. E-mail Address		9. Re-type E-mail Address	

C. Premium Information

Initial Premium Payment Amount $

D. Bank Information

1. Bank Account Type (At this time we do not accept funds from a savings account.)	CHECKING
2. Account Holder Name (Must match the name as it appears on the actual check.)	
3. Routing Number (First 9 digits found on the bottom left of the check.)	
4. Account Number (The number on the bottom right of the check.)	

E. Authorization

I understand that by completing this form I am authorizing Innovation Health/Aetna's representatives to withdraw this FIRST INITIAL PAYMENT from my checking account. This is a one time authorization for the First month premium only.

I understand that this direct payment will be deducted from my checking account within 1 to 2 business days after notification of our group health plan approval. This approval will be sent to my agent by Innovation Health/Aetna.

Sender's Name (Printed)	Sender's Signature
Date Signed (MM/DD/YYYY)	Contact Telephone Number

For Internal Use Only	PSUID	Confirmation Number