APEX HEALTH

MEMORIAL HERMANN Health Plan
MEDICARE ADVANTAGE PLANS

Direct Deposit Authorization

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS (ACH CREDITS)

I (we) hereby authorize Memorial Hermann Health Plan (“COMPANY”) to initiate credit entries to my (our) Checking Account / Savings Account (select one) indicated below at the depository financial institution named below (DEPOSITORY). I (we) agree that the origination of ACH transactions authorized herein shall comply with all applicable U.S. law.

Depository (Bank) Nane ____

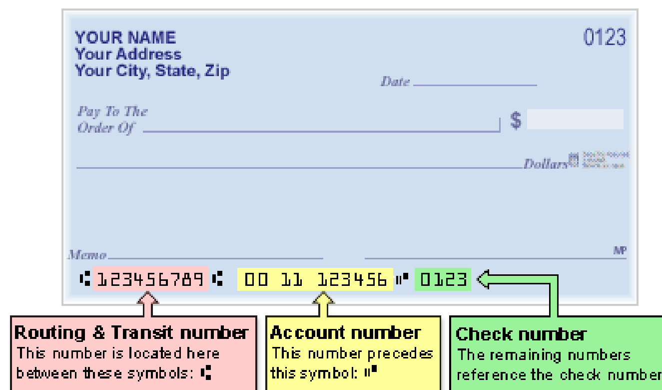
Routing Number: ___________________________ Account Number: _________________________

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination to MASales@apex4health.com at least 3 business days prior to the proposed effective date of the termination of authorization.

Authorized Name:____________________________________ Date: _________________________

Authorized Signature: ____

Check Example:



NOTES:

Written credit authorizations **must** provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization. The blank for notification should be filled with a statement of the time and manner that notification must be given in order to provide company and depository financial institutions a reasonable opportunity to act on it (e.g., “In writing by mail to 100 main street, any town, any that is received at least three (3) days prior to the proposed effective date of the termination of authorization”).Originators should consider obtaining express authorizations of debits or credits to correct errors.