ELECTRONIC FUNDS TRANSFER (EFT)

FOR GROUPS & INDIVIDUALS

Please type or print in black/blue ink only. Incomplete and/or illegible fields and signatures may cause a delay to your enrollment.
Group representatives should complete sections A, C, D, & E. Individual members should complete sections A, B, D, & E.

Section A: Type of Authorization

Please check one: ☐ NEW EFT ENROLLMENT ☐ CHANGE EFT ENROLLMENT ☐ CANCEL EFT ENROLLMENT

Section B: Individual Information *(to be completed by Individuals ONLY)*

First Name: _____ **MI:** _____ **Last Name:** _____

Subscriber ID # (as shown on ID card)**:** _____

Phone Number: _____ **Email**: _____

Section C: Group Information *(to be completed by Groups ONLY)*

Group Name: _____

Group Representative: _____ **Group #** (as shown on ID card)**:** _____

Phone Number: _____ **Email**: _____

Section D: Financial Institution Information

Account Holder Full Name	**Account Holder Billing Address**
Financial Institution Name	**Type of Account (check one)** ☐ CHECKING ☐ SAVINGS **A voided check is NOT required.**
Financial Institution Routing/Transit Number	**Financial Institution Account Number**

Draft Date: 25th of the Month (or the following business day)

Please note: Your account will be drafted on the 25th of each month, or the following business day, for the next month's premium payment. This form must be received by the 15th of the month for the draft to be setup on the aforementioned draft cycle. Until your bank draft is setup, you will need to make a premium payment by mailing a check, via the website or via the phone IVR payment system.
(Example: If you submit your EFT form on February 5th, your first EFT premium payment will occur on February 25th for your March premium.)

Section E: Agreement and Signature

I (we) hereby authorize Alliant Health Plans to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If Alliant Health Plans erroneously deposits funds into my (our) account, I (we) authorize Alliant Health Plans to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle. I (we) understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of a transaction being rejected for Non-Sufficient Funds (NSF), I (we) understand that Alliant Health Plans may at its discretion attempt to process the payment again within 30 days, and agree to an additional $35 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I (we) understand that Alliant Health Plans will cancel an autodraft enrollment that fails for two consecutive months.

I (we) agree to comply with all certification requirements of Alliant Health Plans and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by Alliant Health Plans or its authorized affiliate(s) or subcontractor(s). I (we) understand that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through Alliant Health Plans in accordance with applicable state and federal laws, rules and regulations.

Authorized Signature: _____ Date: _____

Printed Name: _____ Email Address: _____

RETURN THIS FORM TO: Alliant Health Plans
1503 N. Tibbs Road
Dalton, GA 30720

Fax: (706) 229-6287
Email: EFT@AlliantPlans.com

Language Assistance

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Alliant Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 811-4793.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Alliant Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 811-4793.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Alliant Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는(800) 811-4793 로 전화하십시오.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱Alliant Health Plans]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 (800) 811-4793。

તમને વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. આરોગ્ય વીમા વ્યાપારબજાર વિશે દુભાષિયા સાથે ગુજરાતીમાં વાતચીત કરવા, કૉલ કરો (800) 811-4793.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Alliant Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (800) 811-4793.

እርስዎ፣ ወይም እርስዎ የሚረዱት ሰው ስለAlliant Health Plans ጥያቄ ካላቸው፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸው። ከአስተርጓሚ ጋር ለመነጋገር፣ (800) 811-4793 ይደውሉ።

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Alliant Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी भाषषए से बात करने के लिए, (800) 811-4793 पर कॉ करें।

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Alliant Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan (800) 811-4793.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Alliant Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 811-4793.

إذا كان لديك أو لدى شخص تقدم له المساعدة أسئلة بخصوص Alliant Health Plans، فلديك الحق في الحصول على المساعدة والمعلومات اللازمة بلغتك دون أي تكلفة. للتحدث مع مترجم فوري، اتصل بالرقم (800) 811-4793.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Alliant Health Plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (800) 811-4793.

اگر آپ ، یا وہ شخص جس کی آپ مدد کر رہے ہیں ، کو Alliant Health Plans، کے بارے میں سوالات درکار ہیں تو آپ کو حق حاصل ہے کہ آپ اپنی زبان میں بغیر کسی لاگت کے مدد اور معلومات حاصل کریں۔ ترجمان سے بات کرنے کے لیے (800) 811-4793. پر کال کریں

Falls Sie oder jemand, dem Sie helfen, Fragen zum Alliant Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 811-4793 an.

ご本人様、またはお客様の身の回りの方でも Alliant Health Plans についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 811-4793までお電話ください。

TTY/TDD

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-(800) 811-4793 (TTY/TDD: 1-(800) 811-4793).

Non Discrimination

Alliant Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Alliant Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Alliant Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Alliant Health Plans tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Alliant Health Plans 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Alliant Health Plans 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視 任何人。

Alliant Health Plans લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી.

Alliant Health Plans respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Alliant Health Plans የፌደራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት ወይም በጾታ ማንኛውንም ሰው አያገልም።

Alliant Health Plans लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

Alliant Health Plans konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Alliant Health Plans соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Alliant Health Plans يلتزم الأصل الوطني أو السن أو الإعاقة أو الجنس.

Alliant Health Plans cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base naraça, cor, nacionalidade, idade, deficiência ou sexo.

Alliant Health Plans و کند می تبعیت مربوطه فدرال مدنی حقوق قوانین از هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، ملیتی، اصلیت یا ناتوانی سن، جنسیت شود نمی قایل افراد.

Alliant Health Plans erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Alliant Health Plansは適用される連邦公民権法を遵守し、人種、肌の色、出身国、 年齢、障害または性別 に基づく差別をいたしません。