AUTO PAY

FOR BROKERS

Type of Authorization: ☐NEW ☐CHANGE

Tax Payer ID# (TIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___

OR

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Financial Institution Bank Name	Financial Institution Address
Financial Institution Phone Number	**Type of Account (Check one only)**
	☐CHECKING ☐SAVINGS
Financial Institution Routing/Transit Number	**Financial Institution Account Number**

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) 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.

Authorizing Signature _____ Date Signed _____

Printed Name _____ Title of Person Signing _____

Please provide a response to the following question:
For the convenience of having direct deposit, are you willing to download your statement(s) directly from a web site and print them in your own office rather than receive a hard copy in the mail? ☐ YES ☐ NO

RETURN THIS FORM TO:
Alliant Health Plans
PO Box 1128
Dalton, GA 30722