322 Canal Walk • Indianapolis, IN 46202-3268

(317) 261-2060 • Toll free: (800) 257-4762 • www.ismanet.org

Indiana State Medical Association
Group Health Insurance
Authorization for Direct Payment Via ACH (ACH Debit)

Direct Payment Via ACH is the transfer of funds from a consumer account for the purpose of making a payment.

I (we) agree that ACH transactions I (we) authorize comply with all applicable law. I (we) authorize the Indiana State Medical Association to electronically debit my (our) account (and, if necessary, electronically credit my (our) account to correct erroneous debits) as follows:

Insured ID or Master Insured ID (from billing statement) ______________________________

☐ Personal Checking Account ☐ Business Checking Account (select one)

Name of Account Holder ______________________________

Financial Institution Name/City/State ______________________________

Transit/ABA No. ____________________ Account No. ____________________

To assist in verifying this account, please attach a voided check or a copy of a cleared check previously issued to the Indiana State Medical Association paying insurance premiums from this account.

I (we) authorize debit of the balance owed as reflected on the Group Health Insurance Billing Statement to be processed on the 25th day of the month prior to the month(s) of coverage, or on the next business day. I (we) understand that if any payment is returned by the Financial Institution for any reason, I (we) will be responsible for NSF and/or administration charges.

I (we) understand that this authorization will remain in full force and effect until I (we) notify the Indiana State Medical Association in writing by mail to the address above or by fax to (317) 261-2076 that I (we) wish to revoke this authorization. I (we) understand that the Indiana State Medical Association requires at least 3 weeks prior notice in order to cancel this authorization.

Name of Authorized Signer ______________________________ Date ______________

Signature of Authorized Signer ______________________________