AUTO PAY

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 AUTO PAY ENROLLMENT ☐ CHANGE AUTO PAY ENROLLMENT ☐ CANCEL AUTO PAY ENROLLMENT

Section B: Group Information

Group Name: _____

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

Phone Number: _____ **Email**: _____

Section C: 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**

Section D: Agreement and Signature

I (we) hereby authorize Health One Alliance, Inc. and its subsidiaries to present debit entries from the bank account referenced above and the depository named above to debit the same from such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If Health One Alliance, Inc. and its subsidiaries erroneously deposits funds into my (our) account, I (we) authorize Health One Alliance, Inc. and its subsidiaries to initiate the necessary debit entries, not to exceed the total of the original amount credited. I (we) understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates.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 Health One Alliance, Inc. and its subsidiaries 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 Health One Alliance, Inc. and its subsidiaries will cancel an auto draft enrollment that fails for two consecutive months.

I (we) agree to comply with all certification requirements of Health One Alliance, Inc. and its subsidiaries and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by Health One Alliance, Inc. and its subsidiaries 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 Health One Alliance, Inc. and its subsidiaries in accordance with applicable state and federal laws, rules and regulations.

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

Please note: Your payment will be processed 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 Auto Pay to be setup on the aforementioned schedule. Until your Auto Pay is setup, you must make your premium payment by mailing a check, visiting the website or calling the phone IVR payment system.

Account Holder Signature: _____ Date: _____

Printed Name: _____ Relation to Subscriber: _____

Subscriber Signature: _____ Date: _____

Printed Name: _____ Email Address: _____

RETURN THIS FORM TO: 4Corners
PO Box 1128
Dalton, GA 30722

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