NEW MEXICO HEALTH INSURANCE ALLIANCE

Electronic Funds Transfer Form

P. O. Box 5095 • Santa Fe, NM 87502-5095
1-800-204-4700 • 505-989-1600 • Fax: 505-988-3461
Website: www.nmhia.com

NMHIA Account #:__________

Employer Federal Tax ID # or Social Security #:______________________________

Business/Individual Name:______________________________

Address:______________________________

City:______________________ State:__________ Zip:______________

Transfer will occur on the 1st business day of the month.

BANKING INFORMATION

Attach Void Check Here

(Please use tape. DO NOT STAPLE)

Attach a check marked "VOID" so the NMHIA can properly code for premium withdrawal. The check must contain pre-printed bank account name and account number. It is not possible for the void check to be returned. A legible copy of your check is acceptable.

I (We) hereby authorize the NMHIA to draft against my (our) bank account described above, the monthly insurance premium due New Mexico Health Insurance Alliance.
I (We) understand:

(1) The amount of the draft may vary from month to month as the level of enrollment and premium rate may vary;

(2) All requests for termination of group coverage and automatic withdrawals must be made in writing to the NMHIA office;

(3) NMHIA must receive the written request for group termination no later than the 10th of the following the last month of coverage. Premiums for any month following the last intended month of coverage will not be refunded unless notice of termination is received by the NMHIA on or before the 10th of that month. (Note: if the 10th of the month falls on a weekend or holiday, the documentation must be received by the NMHIA, or delivered to its post office box, before 5:00 pm on the next business day);

(4) NMHIA must receive notification of the termination of, or cancellation of insurance for any employee or dependent by the end of the month following the month in which the employee was terminated or his coverage cancelled. **The NMHIA office must receive notice no later than the 10th of the month following the last month of coverage. No premium refunds will be made for written requests received at the NMHIA office after the 10th of the month following the last month of coverage**.

Signature: ______________________________ Date: ______________

Signature: ______________________________ Date: ______________