Health Services Administrators
Insurance Benefits Made Easy

hsainsurance.com

Change Authorization Agreement for Electronic Payment

Client Name: ______________________ 6 Digit HSA Member #: __________

I (we) hereby authorize HSA, hereinafter called COMPANY, to initiate the following changes and debit entries to my (our) Checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to debit the same to such account. This authorization is to remain in full force and effect until COMPANY has received written notification from me (us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Authorized Signer: ______________________ ______________________

Sign Name — Print Name and Title

Date: ______________________ Client Telephone: ______________________

NOTE: ALL WRITTEN DEBIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.

CHANGE IN BANKING INFORMATION

Old Bank Information		New Bank Information	
Old Bank Name:		New Bank Name:	
Old Routing #:		New Routing #:	
Old Account #		New Account #:	
Old Name on Account:		New Name on Account:	

Please attach a copy of a voided check from your new bank.

CHANGE IN DATE OF WITHDRAWAL

Please indicate which date you prefer by checking one of the boxes: ☐ 15th or ☐ 24th

TERMINATION OF ELECTRONIC PAYMENT

Effective Date of Termination: ______________________

Authorized Signer: ______________________ Date: __________

Please remit paper checks as payment of your premium going forward.

Please fax or secure email the completed form and voided check to: (781) 848-7020 or enrollment@hsainsurance.com