MyTru Advantage

ACH Authorization Form

By signing this ACH Authorization Form ("ACH Form"), I hereby authorize MyTruAdvantage or any of its affiliates to credit or debit the account number listed below in connection with processing health plan payment transactions.

FINANCIAL INSTITUTION INFORMATION

Group/Member Name	
Financial Institution Name	
Address	
City/State	
Financial Institution Routing Number	
Financial Institution Account Number	
Start Date of ACH DEBIT	

This ACH Form shall remain in effect unless and until MyTruAdvantage has received written notification from you indicating that your authorization and this ACH Form have been terminated in such time and manner to allow us and our affiliates to act. The undersigned represents and warrants that the person executing this ACH Form is an authorized Signatory on the Account referenced above and all information regarding the Account and Account Owner is true and correct.

SIGNATURE _____ DATE _____