verdegard
Formerly Known as HMA

ACH FORM
Member Automated Clearing House

Member Instructions: Please fill in the information and sign below to allow reimbursement payments to be processed by ACH for the EUTF Supplemental Medical and Prescription Drug Plan.

SECTION 1: MEMBER INFORMATION		
Name:		
Address:		
City:	State:	Zip:
Phone:	Email:	

SECTION 2: BANK INFORMATION		
Bank Name:		
Bank Address:		
City:	State:	Zip:
Bank Phone:	Account Type: ☐ Checking ☐ Savings	
Account Number:	ACH Routing Number:	

SECTION 3: MEMBER SIGNATURE AUTHORIZATION		
I certify that I am the individual indicated above and that I have the authority to enter into this Agreement. I understand that this authorization will remain in effect until it is canceled in writing, and agree to notify Verdegard Administrators, LLC in writing at least 15 days in advance of any changes in its account information or termination of this authorization. I have certified that the above bank account is enabled for ACH transactions, and agree to reimburse Verdegard Administrators, LLC for all penalties and fees incurred as a result of my bank rejecting ACH credits as a result of the account not being properly configured for ACH transactions. By signing I authorize Verdegard Administrators, LLC to initiate/change my reimbursement payment method.		
Authorized Member Name (Please Print):		Date:
Signature of Authorized Member (Required):		Date: