ACH Authorization Form

Fill out the following form to allow Cigna Healthcare Small Group to store and debit payments from your bank account. By submitting this form, you are authorizing Cigna Healthcare Small Group to debit the first month's full premium automatically upon approval. Subsequent payments will be deducted automatically only if auto-pay is selected. ACH payments are easy and will help get your employees their member ID cards faster and easier!

Section A: Business billing information

Billing contact (print full name)	Business name

Group number (if available)

Section B: ACH account information

Account type ☑ Checking ☐ Savings	⑆072404333⑆ 1234567890 Routing number (9 digits) Account number
Bank name	Routing number
Account number	Confirm account number

Section C: Payment settings

☐ **Enroll in auto-pay**
Have your bill automatically paid each month with the bank account you chose in the section above.

☐ **Enroll in paperless billing**
Save paper and have your bill emailed to you and your team each month.

Section D: General agreement

I hereby authorize Cigna Healthcare Small Group, including its parent, affiliates and subsidiaries (Cigna Health and Life Insurance Company) to initiate entries to the checking/savings account at the financial institution listed above, and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until notification that this service has been discontinued, or I notify in writing to cancel it in such time as to afford Cigna Healthcare Small Group and the financial institution a reasonable opportunity to act on my request. I agree to notify in writing of any changes in my account information at least 15 days prior to the next billing date. If payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that ACH debits to the checking/savings account are electronic transactions and funds may be withdrawn from the account as soon as the above noted periodic transaction dates. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form.

Signature of applicant Sign here X	Printed name	Date (mm/dd/yyyy)