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 hne.com/medicare

**HNE MEDICARE ADVANTAGE
 ELECTRONIC FUNDS
 TRANSFER FORM (EFT)**

The undersigned member hereby authorizes and requests Health New England, Inc. (“HNE”) to effect payment for all amounts owed by the member to HNE as such amounts become due. Payment shall be made by initiating credit and/or debit entries to the member’s account in the bank or financial institution indicated below. The member authorizes and requests said bank or financial institution to credit and/or debit the same to such account.

Bank Name _____

Bank Address _____

City _____ State _____ Zip _____

Depositor Account Number _____
 Exactly as it appears on Check or Savings Statement

Checking Account (Include Voided Check) Savings Account (Include Routing #)

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This authorization is active as of the date written below and shall remain in effect until terminated. The member may terminate this authorization without cause by giving fifteen (15) days prior written notice to HNE. HNE may terminate this authorization without cause at any time.

PLEASE INDICATE THE TYPE OF REQUEST:

New Enrollment Change to Enrollment Cancel Enrollment — Termination Date: _____

Member Name: _____

Member Address: _____

Member ID Number: _____

Signature: _____ Date: _____

HNE Medicare Advantage is an HMO plan with a Medicare contract.
 Enrollment in HNE Medicare Advantage depends on contract renewal.