AUTHORIZATION FOR MONTHLY BANK WITHDRAWAL

INDIVIDUAL POLICIES ONLY

WellCare

WellCare Health Plan
P.O. Box 31367 Tampa, FL
33631-3367

For office use only:
ID # _____
Effective Date:_____
PDP

First Name _____ Middle Initial _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Subscriber ID Number:

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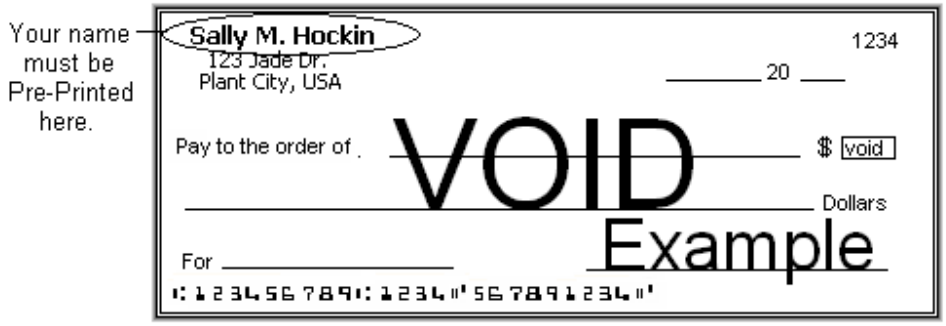
Plan Chosen:_____

Branch Name:_____

Bank Name:_____ Branch Address:_____

Checking Account Info: *Note, your financial institution may not accept electronic funds transfers (EFTs). Only one applicant per form. Married members need separate forms and bank documentation.
Attach an original voided check here. (*No photocopies or deposit tickets accepted.)



Savings Account Information: Please provide a letter from your bank, on their letterhead, signed by a bank representative, with your savings account number and routing information on it.

Monthly Premium: $_____ (Amount subject to change upon renewal or change in enrollment.)
YOUR EFT WILL GO INTO EFFECT AS SOON AS YOUR COMPLETED ELECTION FORM IS PROCESSED WHICH MAY TAKE UP TO ONE TO TWO BILLING PERIODS. A SINGLE MONTHLY PREMIUM WILL BE DEDUCTED FROM YOUR ACCOUNT. YOU SHOULD KEEP PAYING YOUR MONTHLY BILL UNTIL YOU ARE NOTIFIED THAT THE EFT WITHDRAWAL WILL START.

CERTIFICATION AND AUTHORIZATION

I, the undersigned, hereby authorize WellCare Health Plan to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entry to the account indicated above and the financial institution named above and to debit and/or credit same to such account. This authorization is to remain in full force and effect until WellCare Health Plan has received written notification from me of its termination by the 10th of the month.

Authorization Signature: _____ Date: _____

WellCare Health Plan P.O. Box 31367 Tampa, FL 33631-3367
1-888-550-5252 TTY / TDD: 1-888-816-5252
Monday-Sunday, 7am to 2am Eastern

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