SARASOTA MEMORIAL HEALTH CARE SYSTEM

CHARTER HEALTH PLAN

A big idea for small business

Agreement for Pre-Authorized Payments
(Automated Clearing House [ACH] DEBITS)

COMPANY Name: SARASOTA MEMORIAL HEALTH CARE SYSTEM

I (we) hereby authorize SARASOTA MEMORIAL HEALTH CARE SYSTEM, hereinafter called COMPANY, to initiate debit entries to my (our) checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to debit the same to such account.

DEPOSITORY/BANK Name: _____

City: _____ State _____ Zip _____

Transit/ABA No. _____ Account No. _____

This authority is to remain in full force and effect until COMPANY has received written notification from me (or signer of the Depository) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. NOTE: ANY ACTION RESULTING IN AN ACH RETURN MAY RESULT IN IMMEDIATE TERMINATION OF THE GROUP.

_____ _____

Officer / Owner Name (Please Print) **Officer / Owner Signature**

_____ _____

Business Name **Date**

****

Second signature, if applicable

_____ _____

Officer / Owner Name (Please Print) **Officer / Owner Signature**

_____ _____

Business Name **Date**

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**** ATTACH VOIDED CHECK TO THIS DOCUMENT****