healthfirst
Health Insurance for New Yorkers

Initial Payment Authorization form*

SECTION A: BUSINESS BILLING INFORMATION

Billing contact (full name)		Business name	
Business billing address (Not P.O. Box)			
City	State	Zip Code	County
Email address		Phone number	

SECTION B: ACH ACCOUNT INFORMATION

Initial premium amount $

Account type ☐ Checking ☐ Savings		⑆123456789⑆ 0001234567890⑈	
		9 DIGIT ROUTING NUMBER	YOUR ACCOUNT NUMBER
Bank name		Routing number	
Account number		Confirmation account number	

SECTION C: GENERAL AGREEMENT

I (we) hereby authorize Healthfirst Insurance Company, Inc. ("Healthfirst") to initiate entries to my (our) checking/savings accounts at The Financial Institution listed above, and, if necessary, initiate adjustments for any transactions credited/debited in error. Once ACH information is received, Healthfirst will charge the account and funds may be withdrawn prior to the effective date of coverage. This authorization is only for the initial payment associated with my coverage.

SIGN HERE	Signature of Applicant	Printed Name	Date

*This is for an initial payment and will be charged one-time.