



Payee Name: _____

John Doe 123 Main Street Anywhere, US 12121	5555 Date
Pay to the Order of _____	\$ _____ Dollars
<i>County Bank</i>	
For _____	
Bank Routing Number _____	Account Number _____

Preferred Method of Payment: Electronic Funds Transfer Check

_____ (“Payee”) hereby (1) authorizes Coventry Health Care, Inc. and its corporate affiliates (collectively “CHC”) to make payments for Payee’s services by Electronic Fund Transfer (EFT), (2) certifies that the Payee has selected the following depository institution, and (3) directs that all such EFT’s be made as provided below:

Depository Institution: _____

Bank Routing Number: _____ Account Number: _____

Account Type: Checking Savings

Payee’s Tax Id or Social Security Number: _____

Payee will give thirty (30) days advance notice in writing to CHC of any changes in its depository institution or other payment instructions.

When properly executed, this Authorization will become effective within thirty (30) days after its receipt by CHC. CHC also reserves the right to recall an EFT transaction if incorrect.

Before submitting this authorization form, the Payee should check with its banking institution to verify that it will be able to receive Automated Clearing House (ACH) transactions and if there are any associated fees for this service. To ensure the correct banking information is entered into our system, please attach a copy of a voided check for the depositing account.

Authorized Signature

Title

Date