If you would like to have your monthly premium deducted from your bank account, please complete the below information and Mail or Fax this form and copy of a cancelled check to:

East End Health Plan
C/o Eastern Suffolk BOCES
201 Sunrise Highway
Patchogue, New York 11772

Fax Number: 631-687-3067

Remember, premiums are billed one month in advance. Deductions are made on about the 15th of the month.

REQUEST FOR AUTOMATIC DEDUCTION OF HEALTH INSURANCE PREMIUM

I, ______________________________ request the withdrawal of my monthly East End Health Plan premium
(print your name)

from my Checking/Savings account number __________________________ ________________________
(Circle one) **(Bank routing number)** **(Account number)**

with ___________________________________bank, effective ________________________.
(Name of Bank) **(Date you want to begin deduction)**

My current monthly amount is $______________

ATTACH A COPY OF A VOID CHECK HERE

__________________________ ____
Date **Signature**

____
EEHP ID Number

____
Mailing Address

____

____
E-Mail Address

____
Telephone Number