East End Health Plan

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
Mr. Frank Perry, Operations Administrator
201 Sunrise Highway
Patchogue, New York 11772
Fax: 631-687-3067

Remember, premiums are billed one month in advance. Deductions are made on the last business day of the prior month.

REQUEST FOR AUTOMATIC DEDUCTION OF HEALTH INSURANCE PREMIUM

CHECK ONE: ☐ New ACH Request ☐ Change of Account Information

I, _____, request the withdrawal of my monthly East End Health Plan premium
(PRINT YOUR NAME)

from my (**CHECK ONE**): ☐ Checking Account Number _____

☐ Savings Account Number _____

with _____Bank, Bank Routing # _____
(NAME OF BANK) **(BANK ROUTING # AS IT APPEARS ON YOUR CHECK)**

Effective _____ My current monthly amount is $_____
(DATE YOU WANT TO BEGIN DEDUCTION)

School District Name: _____
(CURRENTLY EMPLOYED WITH OR RETIRED FROM)

PLEASE INCLUDE A COPY OF A VOIDED CHECK or SAVINGS ACCOUNT DEPOSIT SLIP WITH THIS FORM.

_____
Signature

_____
EEHP ID NUMBER
(As it appears on your Invoice from J.J. Stanis)

_____
Mailing Address

_____
(City, State and Zip Code)

_____
E-Mail Address

_____
Telephone Number