Electronic Funds Transfer (EFT) Form

When you sign up for EFT, your monthly premium payment is automatically deducted from your checking or savings account each month and transferred to CarePartners of Connecticut.

How to Sign Up

Complete this form and mail it to:

CarePartners of Connecticut
Attention: EFT Enrollment
1 Wellness Way, Mail Stop D4
Canton, MA 02021

We will contact you by mail when your application has been approved. Please continue to pay your monthly premium until we notify you of your enrollment in the EFT program.

Member Information

Member name

Member ID number

Member phone number

Street

City/Town

State

Zip

Account Information

Reason for EFT authorization

☐ New application ☐ Change bank account

Name of bank or financial institution

Name of account holder

Phone number of account holder

Account number

Account type

☐ Checking

☐ Savings

Routing number*

*You can find your 9-digit routing number in the bottom left corner of your check. If using a savings account, this number can be obtained from your bank.

Please attach a check marked "VOID" with the checking account number you want your CarePartners of Connecticut monthly plan premium withdrawn from.

Signature needed on back

EFT Withdrawal Information

Your monthly plan premium will be withdrawn from your account on the 9th of every month. The withdrawal will occur on the following business day if the 9th falls on a Saturday, Sunday, or holiday. **Please note that deductions will include any outstanding premiums due on the EFT withdrawal date.**

Checking/Savings Account Authorization Agreement

I hereby authorize the monthly debit to the account referenced above. I understand that I should continue to pay my monthly premium until I receive written confirmation from CarePartners of Connecticut confirming the activation and start date of electronic funds transfer from my account. I understand that my account must have the full dollar amount due in available funds on a monthly basis. I understand that my bank may charge a fee if there are insufficient or uncollected funds in my account. I understand that CarePartners of Connecticut retains the right to revoke or change my participation in the EFT program at any time. I also understand that I have the right to stop automatic payments by notifying CarePartners of Connecticut by phone or in writing before the 8th of the month in order to discontinue for the following month.

Signature

Print name ______________________________

Date ______________

CarePartners of Connecticut will not disclose your banking information to any third parties unless you authorize us to do so.

CarePartners of Connecticut complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-341-1507 (TTY: 711). Y0151_2022_22_C