Questions? Please call 1-888-222-9931

Mail or Fax completed form to:
MVP Health Care, Inc. | Attn: Flex Department
120 Madison St., Suite 1000, Tower 2
Syracuse, NY 13202
Fax: 1-315-234-6146

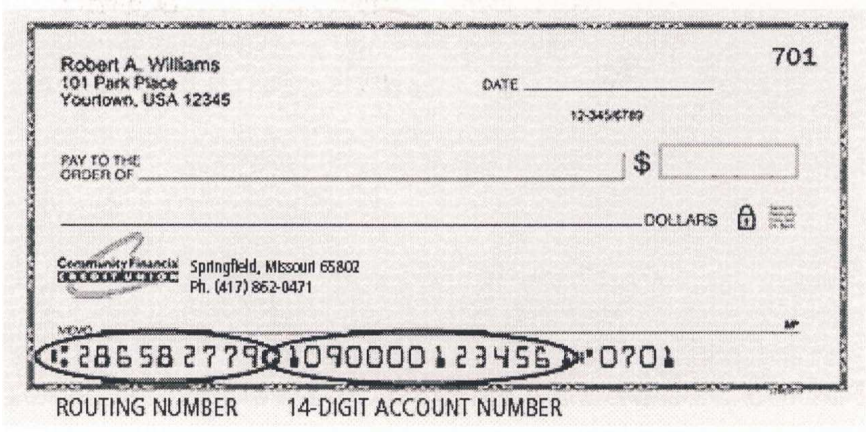
MVP Select Care Inc. Electronic Funds Transfer Agreement

Group Name		
Last Name	**First Name**	**Social Security Number**
E-mail Address	**Home Phone Number** ( )	**Daytime Phone Number** ( )

Please Select One: **NEW ENROLLMENT** **ACCOUNT CHANGE** **CHANGE EFFECTIVE DATE: _____/_____/_____**

CANCEL ELECTRONIC FUNDS TRANSFER **CANCEL EFFECTIVE DATE: _____/_____/_____**

Bank Name	**Checking** **Savings**
Routing/ABA Number	**Account Number**



PLEASE ATTACH A VOIDED CHECK (FOR CHECKING ACCOUNT DEPOSITS) OR DEPOSIT SLIP (FOR SAVINGS ACCOUNT DEPOSITS) HERE.

THIS MUST BE INCLUDED TO PROCESS –
INCOMPLETE FORMS WILL BE RETURNED.

Employee Authorization

I authorize MVP Select Care, Inc. and its financial institution to initiate credit, and if necessary, debit entries, electronically or otherwise, to my checking or savings account. Debit entries will only be made to correct credit entries made in error. Further, I may be responsible for any bank fees incurred due to incorrect account information or account changes that have not been appropriately communicated to MVP Select Care, Inc. This authorization will remain in effect until MVP Select Care, Inc. has received written notification.

Employee Signature: _____ Date: _____

Questions? Please call 1-888-222-9931