



Western Health Advantage Electronic Funds Transfer Agreement

Group Name _____

Group Number _____

Effective Date _____

Contact person _____

Contact phone # _____

Bank Name _____

Branch Address _____

Bank Account # _____

Bank Routing # _____

This agreement is between Western Health Advantage (WHA) and the participating group for electronic payment transfer of funds. The funds will be transferred on the last day of each month for the amount of the current invoice. Invoices are mailed on the 17th of each month. Any changes to enrollment will be taken into account on the following month invoice. If the funds are not available on the last day of the month, WHA will notify the group to make arrangements for payment.

Authorized signature _____

Title _____

Date _____