



### ACH Adjustment Authorization/Change of Information Form

I hereby authorize Avalon Healthcare, Inc. to debit my monthly approved premium to my  Checking  Savings

\_\_\_\_\_  
Amount Account Number Routing Number

\_\_\_\_\_  
Account Holder's Signature Date

\_\_\_\_\_  
Name on the Account  Self  Spouse  Parent  Legal Guardian  
Relationship to Primary Applicant

\_\_\_\_\_  
Bank Name Bank Address Bank Phone No.

\_\_\_\_\_  
Effective Date of Change

As part of the application process for an Avalon Healthcare IFocus Plan, you may be asked to supply electronic payment information to us for an ACH bank draft. If you are approved for coverage and you accept the offer of coverage along with returning all requested paperwork to us, your bank account will be debited on the business day following approval.

For recurring electronic payments of policy premiums, the payments will be processed three business days prior to the coverage month based on the term and frequency established at the time recurring payments are setup. When canceling an active policy, fifteen days notice prior to the termination date is required. Coverage will then be terminated the last day of the month premium was received.

If you have further questions regarding this return policy or the application process, please contact Avalon Member Services at (866) 469-2347 or email us at [billing@avalonhealthcare.net](mailto:billing@avalonhealthcare.net).

**Please mail or fax completed form to:**

**Avalon Healthcare, Inc.  
Attn: Administration  
3030 N. Rocky Point Dr. W. Ste #800  
Tampa, Florida 33607**

**Fax: (877) 280-8881**