East End Health Plan

Mail or Fax this form and copy of a cancelled check to:

East End Health Plan
c/o Eastern Suffolk BOCES
201 Sunrise Highway
Patchogue, New York 11772
Fax Number: 631-687-3067

REQUEST FOR AUTOMATIC DEDUCTION OF HEALTH INSURANCE PREMIUM

I, _____ request the withdrawal of my monthly East End Health Plan Premium
(print your name)

from my (Checking/Savings) account number _____ _____ _____
(Circle one) (Bank routing number) (Account number)

with _____ bank, effective _____
(Name of bank) (Date you want to begin deduction)

My currently monthly amount is $_____

ATTACH A COPY OF A VOID CHECK HERE

_____
Signature

_____
East End Health Plan ID Number

_____
Mailing Address

_____
City, State, ZIP

_____
Telephone Number