Direct Debit Enrollment

Company Name _____

Address _____

_____

_____

Case Number _____

Bank Account Number _____

Bank Routing (ABA) Number _____

Checking ☐ Savings ☐

Bank Name _____

Bank Address _____

_____

_____

Remember to include a voided check.

I authorize CBIA Service Corp to debit the account specified above for payment of insurance premium due. I understand that I must notify CBIA Service Corp in writing if the account information changes, or to stop the direct debit authorization. I also understand that CBIA Service Corp may charge a $25 fee for each instance in which there are insufficient funds in the specified bank account when the direct debit transaction occurs.

Signed_____ Date _____

Print name and title_____

Phone number_____

Fax to: 860.278.0883

Mail to: ConnectiCare Small Group Administration
c/o CBIA Service Corp.
350 Church Street
Hartford CT 06103-1126