



CENTRAL HEALTH

TRAVIS COUNTY HOSPITAL DISTRICT

ELECTRONIC FUNDS TRANSFER INFORMATION

Please complete, sign and date the bottom of the form.		
Type of Election: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Bank Information <input type="checkbox"/> Discontinue EFT		
Company Name:		Phone:
		Fax:
Address:		
City, State, Zip:		
I authorize the Travis County Healthcare District (TCHD) dba Central Health to deposit by electronic transfer payments owed to me by TCHD and, if necessary, debit entries and adjustments for any amounts deposited electronically in error. TCHD shall deposit the payments in the financial institution and account designated below. I recognize that if I fail to provide complete and accurate information on this authorization form, the processing of the form may be delayed or that my payments may be erroneously transferred electronically.		
I consent to and agree to comply with the National Automated Clearing House Association Rules and Regulations and TCHD's rules about electronic transfers as they exist on the date of my signature on this form or as subsequently adopted, amended or repealed.		
Financial Institution Name:		Telephone Number:
Financial Institution Street Address:		
City, State, Zip:		
Bank Routing Number:		
Bank Account Number:		
Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		
Employee Name (<i>Print</i>):		Email Address:
Signature:	Department:	Date:

PLEASE EMAIL FORM TO

finance@centralhealth.net

Email address to send Payment Notifications to: _____