Nebraska Comprehensive Health Insurance Pool

Administered by Coventry Health and Life Insurance Company
P.O. Box 541210 Omaha, NE 68154 | Phone: 855-247-5201 (Toll Free) | Fax: 866-799-9448 | www.nechip.com

Debit Authorization Form

☐ Check if Changing Bank (Complete entire form)
☐ Check if new account number at same bank (Complete entire form)
☐ Check if new debit authorization (Complete entire form)
☐ Check if changing from bank debit to bill direct (Complete Sections A, B, C & Signature)

A. Social Security Number/ID Number	B. Insured's Name (Last, First, M.I., Title)

C. Address (Street, P.O. Box, City, State, Zip + 4 Code, County)

D. Financial Institution	E. Group Number	F. Town/City	G. Account Number	☐ Checking ☐ Savings

H. DEBIT AUTHORIZATION (FOR INTERNAL USE ONLY)

I authorize Nebraska Comprehensive Health Insurance Pool to initiate debit entries (charges) to my account indicated in section G. and the Financial Institution named in section E. to charge the said account.

This authority is to remain in full force and effect until the Financial Institution has received written notification from me of its termination in such time as to afford the Financial Institution a reasonable opportunity to act on it.

The initial authorization is for $ _____ to be charged to my account on or after the 15th day of each month. Such amount may be changed from time to time by Nebraska Comprehensive Health Insurance Pool giving me written notice before changing said amount.

Customer's Name _____ Insured's Phone # _____
(As it appears on your account) *Please Print*

Customer's Signature: _____ Date: _____
(Authorized signer on your account)

If different than Member, indicate your relationship: _____

If above signature is that of an employer, please complete the back of this form.

Please include a voided check on the account to be used in the future.

Attach VOIDED Check Here

Return this form & check to:

NEBRASKA COMPREHENSIVE HEALTH INSURANCE POOL
ACH Processing Department
PO Box 2292
Omaha NE 68108-2292
FAX (402) 991-5374

To be completed only if employer signature is used on previous page.

Name of Applicant: _____

Social Security Number of Applicant: _____

I certify that employer contribution to the above applicant's health insurance policy does not violate the Health Insurance Portability Act of 1996 (HIPAA) because:

☐ The premiums being debited from the business account are being totally reimbursed by means of payroll deduction.

I certify the truthfulness of the above statement. I understand that fines and penalties may be imposed upon an employer and an insurer for violation of HIPAA provisions relating to creditable coverage, nondiscrimination, and limitations on pre-existing conditions. I agree to hold Coventry Health and Life Insurance Company harmless from any fines or liability if the above certifications are incorrect.

Name and Address of Business Entity: _____

_____

_____

_____

By: _____ Date: _____

Signature & Title