For Office Use Only:
ID #
Effective Date:

Wellcare Health Plans, Inc.
Attention: *Cash Department*
P.O. Box 31367
Tampa, FL 33631-3367

EFT - *Electronic Fund Transfer Authorization*

Section A

Member Subscriber ID Number with Wellcare**:**
Name of Member Last , First, Initial :
Member Contact Phone Number:

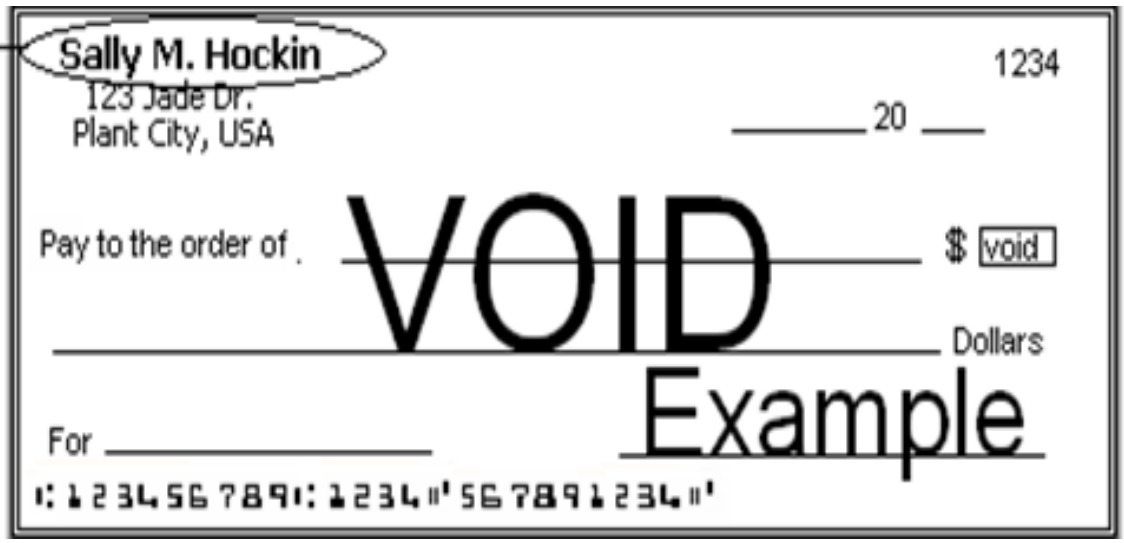
PLEASE NOTE: ONE FORM is needed for each member's account including married couples.

Section B – Choose the account type to be used:

☐ Withdrawals from a **CHECKING ACCOUNT** need an original voided check with your name printed on it for processing.

Staple or Paper Clip your Check

Your name must be Pre-Printed here.



☐ Withdrawals from a **SAVINGS ACCOUNT** require a letter from your bank, on their letterhead, signed by a bank representative, with your savings account number and routing information on it.

Section C

Name of Payer if *Not The Member*:
Phone Number of Payer if *Not The Member*:
Signature of Payer *if Not Member*:
Your EFT will go into effect as soon as your completed election form is processed which may take up to 2 more months. You should keep paying your monthly bill until you are notified that the EFT will start. EFT withdrawals will be drafted between the 15th thru 20th of each month. **(The amount drafted is subject to change upon renewal or change in enrollment)**
I, the undersigned, hereby authorize Wellcare Health Plan to initiate EFT drafts from my account listed above and if necessary initiate credits to offset prior debits. **The authorization is to remain in full force and effect until Wellcare has received written notification from me for termination by the 10th of the month.**
Member Authorization Signature: **Date:**