



**AUTOMATIC CONTRIBUTION PAYMENT
ELECTRONIC FUNDS TRANSFER (EFT)**

I authorize Inspira Financial Health, Inc. ("Inspira") to initiate debit and/or credit entries to the account designated below for payment of my monthly insurance benefit contributions. This agreement will remain in full effect until Inspira receives written instruction from me to rescind this authorization.

PART 1: PARTICIPANT INFORMATION

Name: _____ Participant ID: _____

Signature _____ Date: _____

IMPORTANT: You will receive a confirmation letter, with the effective date denoted, once your EFT is set up by Inspira. Please continue to mail payments until you have received the confirmation.

PART 2: FINANCIAL INSTITUTION

Name of Financial Institution: _____

Account Type: Checking Savings Other

ABA Routing Number:

Account Number:

The bank routing number can be found in the lower left hand corner of your check and is usually the first 9 digit number. Your bank account number is usually found next to the routing number, as shown on the illustration below.



Attach a copy of a voided check to this form and mail to:

Inspira Financial Health, Inc.
BENEFIT BILLING DEPARTMENT
PO BOX 953374
ST. LOUIS, MO 63195-3374