CBIA

Connecticut Business & Industry Association

Direct Debit Enrollment

Company Name _____

Case Number _____

Address _____

_____

_____

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 health 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_____

Print name and title_____

Phone number_____

Mail to: Cindy Carta
CBIA
350 Church Street
Hartford CT 06103-1126

Fax to: 860.278.0883