# Electronic Funds Transfer (EFT) Enrollment Form

Asterisk (*) indicates required fields

**Please complete and return this form in order to receive electronic payments from Assist Health Group.**
**Forms should be returned to ach@assisthealthgroup.com**

## Organization Information

Organization Name* _____

Organization Address* _____

City* _____

State* _____ Zip Code* _____

Organization Phone Number* _____

## Tax Information

Tax Identification Number (TIN)* _____

## Administrator Contact Information

First Name* _____

Last Name* _____

Email Address* _____

Phone Number* _____

Fax* _____

## Bank Account Information

Legal Name on Bank Account* _____

Name of Financial Institution* _____

Routing Number* _____

Account Number* _____

Account Type* ☐ Checking ☐ Savings

_____
Signature

Name: _____
Date: _____