Electronic Funds Transfer (EFT) Change Authorization Form

I authorize Allstate to withdraw future payments from the account listed below. Allstate Health Solutions or I may terminate this agreement by written notice to the other party. I may also call Allstate Health Solutions at 888-781-0585 to make changes to my account information or method of payment.

Insured's Name: _____ Policy #(s): _____

Date of Birth: _____

Electronic Funds Transfer

Bank Routing #: ☐ Checking Account ☐ Savings Account

Checking Account #: ____ ____ ____ ____ ____ ____ ____ ____ ____ *9 Digits on the bottom left of check*

_____ *Enclose a voided check*

NOTE: **Please allow 30-days from time of submission for changes to become active**.

Signature: _____ Phone#: _____

Please return completed form to:
Allstate Health Solutions
Fax: 888-344-3232
PO BOX 1070
Winston Salem, NC 27102-1070