

Company Debit Account Deposit Form



I am including a check or an authorization to charge a credit card, to place funds in my company's account for the purpose of payment for any product sold through the AHIP's Center for Insurance Education and Professional Development store. I understand that no charges against this account will be processed without prior authorization from the designated Company Payment Administrator. I also understand that the balance is not subject to expiration, and can be refunded anytime upon request.

Contact Person Information

Name _____ Title _____
Phone _____ Fax _____ Email _____

Company Information

Name: _____ Company ID (if known): _____
Address: _____

Payment Method

Check - A check is enclosed in the amount of \$ _____ (*payable to America's Health Insurance Plans*)

Credit Card - Amount to be charged \$ _____

Name (as it appears on the card) _____

Credit card Billing Address _____

Credit card Number _____ Exp. _____

Authorized Signature _____ Date _____

To Complete a Check deposit on your account, Please return this form to:

America's Health Insurance Plans
PO Box 418091
Boston, MA 02241-8091

If sending via Express Courier:

America's Health Insurance Plans
Lockbox 418091
MA5-527-02-07
2 Morrissey Blvd.
Dorchester, MA 02125

To Complete a Credit Card deposit on your account, please return this form to.....OR.....Fax it to:

America's Health Insurance Plans 202.955.4397
Finance Department
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004