INCLUSIVE HEALTH
FEDERAL OPTION

Mail completed form to:
Inclusive Health
P.O. Box 2302
Mt. Clemens, MI 48046-2302

Application # _____

Member ID # _____

Please Note: The Banking information given below must be from a Personal Account and not a Business Account.

Automated Clearinghouse Authorization Agreement

Inclusive Health through its administrator, Coresource, is hereby authorized to deduct my Inclusive Health premium payment due them by electronic debit entries to my checking or savings account indicated below.

Name of Account Holder: _____

Bank Name: _____

Account Type: ☐ Checking ☐ Savings Routing #: _____ Account #.: _____

Bank Address: _____

City: _____ State: _____ Zip Code: _____

Signature of Account Holder(s): X _____

Account Holder(s) Name(s) (Print): _____

Signature of Account Holder(s): X _____

Account Holder(s) Name(s) (Print): _____

ATTACH A VOIDED CHECK OR SAVINGS ACCOUNT DEPOSIT SLIP HERE