Members have two options for automatic premium payment.

1. **Your bank** (checking or savings)—Fill out the middle panel of this brochure. Your payment will be pulled on the tenth of the month, or the nearest business day. For checking, be sure to enclose a voided check.

2. **Credit card**—Fill out the information on the other side of this panel. Your payment will be pulled on the first of the month, or the nearest business day.

After completing the appropriate form, please mail it back to us in the envelope provided.

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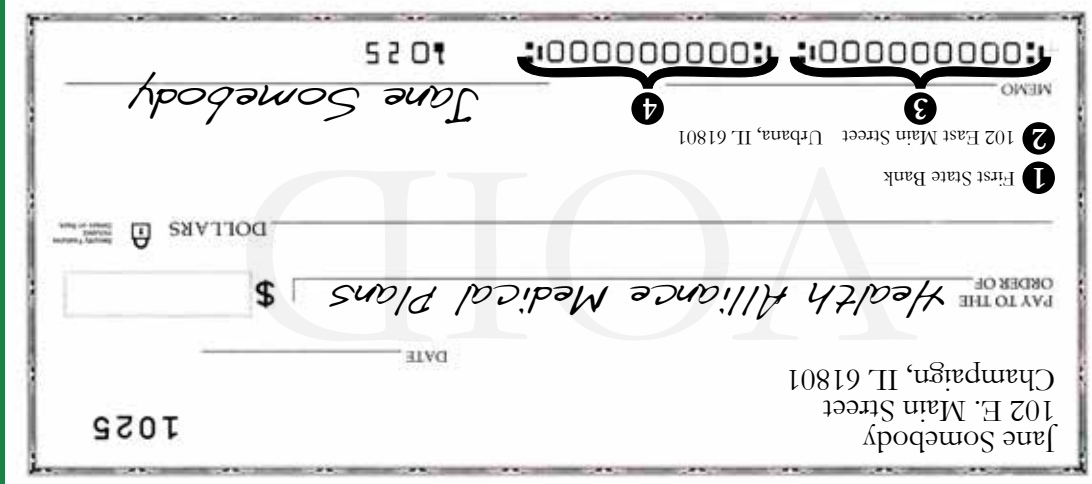

Sample voided check

1. Name of financial institution
2. Branch, City, State, ZIP
3. ABA routing number
4. Account number

Health Alliance MEDICARE℠

Automatic
Premium Payment Program

Timesaving • Worry-free • Convenient • Dependable

Enjoy the security of knowing your monthly plan premium is on time with our Automatic Premium Payment Program. It's an easy, dependable way to make your plan premium payments.

How Automatic Payment Works

Health Alliance Medicare will deduct your plan premium from your bank account every month. If you have any questions, please call Health Alliance Medicare Services at 1-800-965-4022 or TTY/TTD 711. Representatives are available from 8 a.m. to 8 p.m. weekdays.

If the amount of your plan premium changes, we will inform you at least 30 days in advance.

1 Automatic Premium Payment Authorization (please print)

Name (First, Middle Initial, Last) _____

Social Security Number ___ ___ ____

Phone Number ( ) _____

Make this deduction from:

☐ Checking (Enclosed voided check) ☐ Savings

See voided check sample on back for this information.

Financial Institution of Payor

Name _____

Branch _____

City _____ State _____ ZIP _____

ABA# _____

Account# _____

I hereby authorize Health Alliance Medical Plans, Inc., and the financial institution named above to initiate monthly debit entries, on the appropriate date and in the amount of the current premium for my plan, and to initiate, if necessary, credit entries and adjustments for any debit entries in error to the account and financial institution indicated above. This authority is to remain in effect until Health Alliance has received written notification from me of its termination in such time as to afford Health Alliance and the financial institution a reasonable opportunity to act on it.

Signature _____ Date _____

2 Authorization for Monthly Recurring Credit Card Transactions for Payment of Health Premium.

I hereby authorize Health Alliance to keep my signature on file and to process a monthly recurring credit card transaction for payment of my health insurance premium which is processed on the 1st of every month. I understand this will begin with my next payment.

I acknowledge that this recurring payment will continue until the expiration date of the credit card listed below or until I notify Health Alliance in writing to discontinue the recurring payment.

Member name: _____

Member number (if known): _____

Cardholder name: _____

Card type: ☐ Visa ☐ MasterCard ☐ Discover

Credit card number: _____

Expiration month/year: _____

Cardholder billing address: _____

City, State, ZIP: _____

Three-digit security code located on the back of the card in the signature strip: _____

Cardholder signature: _____

Date: _____