Automatic Premium Payment Program

Sign up for automatic payments and enjoy knowing your payment is always on time. It's the easy way to pay. To get started, choose whether you'd like to pay using your credit card OR pay from your checking or savings account.

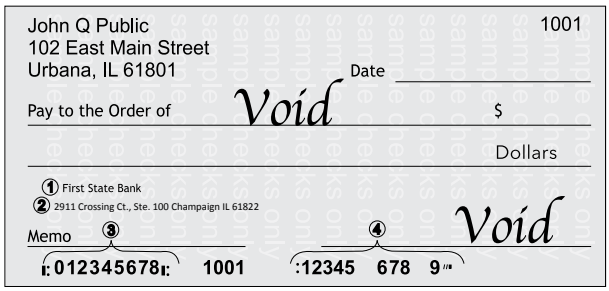
If you'd like to pay using your credit card, please visit HealthAlliance.org/Payment to set up your member account and payment information. You'll be able to set up automatic monthly payments using your Visa, Mastercard or Discover credit card, and you can choose any day between the 1st and the 12th of the month.

Note:

- If you're a new member, watch for your welcome letter and member number in the mail. You'll need this to sign up for your online member account.
- You must be enrolled to set up your online member account.

If you'd like to pay from your checking or savings account, fill out this form and send it (along with a voided check if paying from your checking account) to us using one of the following methods:

Fax: (217) 902-9784
Email: Autodraw@HealthAlliance.org
Mail: Attn: Autodraw
Health Alliance
3310 Fields South Dr.
Champaign, IL 61822



Note: Your payment will happen on the first day of each month or on the closest business day.

Sample Voided Check

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

Automatic Premium Payment Authorization (Please print.)

Name (First, Middle Initial, Last)	See voided check sample for this information. **Financial Institution of Payor Name**
Social Security Number	
Phone Number	**Branch**
Make this deduction from: ☐ **Checking** (Enclose voided check.) ☐ **Savings**	**City**
Would you like this to apply to your initial payment? If you select "No," or don't make a selection, you'll have to make an initial payment separately. ☐ **Yes*** ☐ **No** * Premiums are pulled once the application is processed, not on the effective date.	**State** / **ZIP** **Routing#** **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 _____

If you have any questions, please call our Customer Service Department at the number listed on the back of your ID card.

Health Alliance™