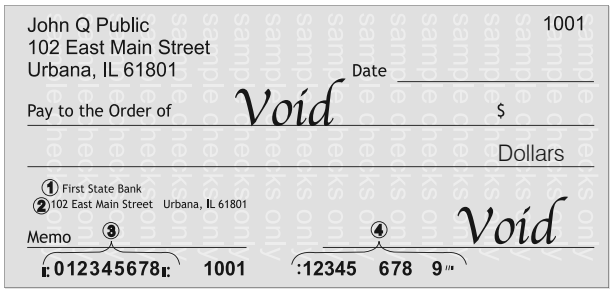
Automatic Premium Payment Program

Sign up for automatic payments and enjoy knowing your payment is on time. It's the easy way to pay. Your payment will happen on the first day of each month or on the closest business day. If the amount is going to change, we'll let you know at least 30 days before it does.

If you have any questions, please call our Customer Service Department at 1-866-247-3296, Monday through Friday, 8 a.m. to 5 p.m.

To get started, choose one of the options below and fill out the form.
Option A – Pay from your checking or savings account.
Option B – Pay with your credit card.



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

Option A* – Automatic Premium Payment Authorization (please print)

Name (First, Middle Initial, Last)

Social Security Number

Phone Number ( )

Make this deduction from:

☐ **Checking** (Enclose voided check) ☐ **Savings**

See voided check sample for this information.

Financial Institution of Payor

Name _____

Branch _____

City _____ **State** _____ **ZIP** _____

ABA# _____

Account# _____

Would you like this to apply to your initial payment? If you select "no" you will have to make an initial payment separately.

❑ **Yes** ❑ **No**

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 _____

Option B* – Authorization for Monthly Recurring Credit Card Transactions to Pay Premium (please print)

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.

Would you like this to apply to your initial payment?
If you select "no" you will have to make an initial payment separately.
❑ **Yes** ❑ **No**

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: _____

Fax: 217-902-9784
Email Address: Autodraw@HealthAlliance.org
Mailing Address: Health Alliance
3310 Fields South Drive
Champaign, IL 61822

*Premiums are pulled once the application is processed and not on the effective date.