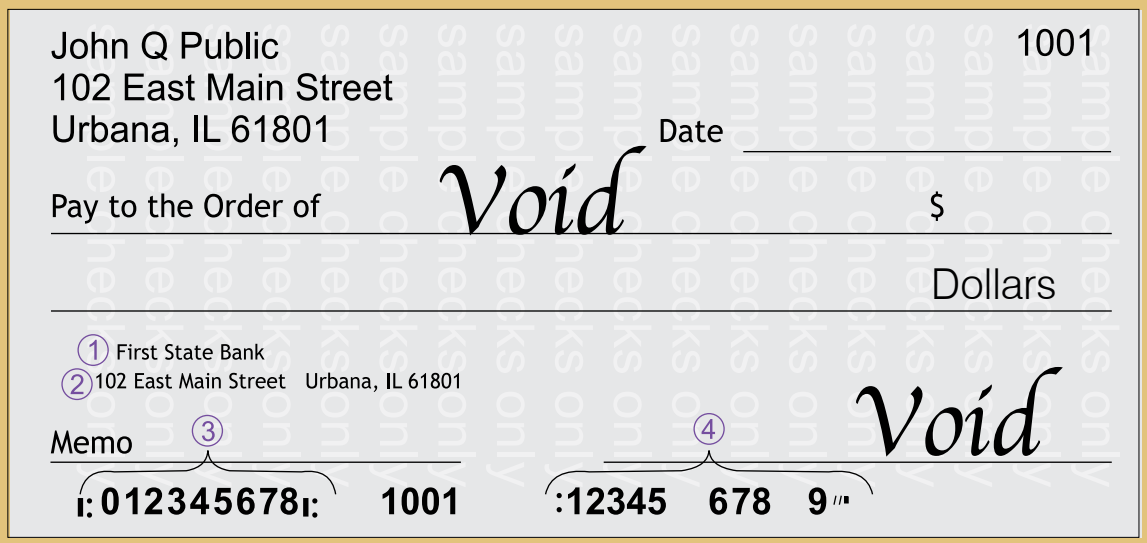
If you have any questions about your options for payment, please call our Customer Service Department at 1-866-247-3296, Monday through Friday, from 8 a.m. to 5 p.m.

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

To sign up for recurring credit card transactions, please complete the form in **Option B** and return it in the provided envelope.



Sample voided check

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

Health Alliance INDIVIDUAL PLANS℠

What's Best? You Choose.

Whether you want your monthly premium to be taken out of your bank account or you want to pay it all up front, you have options with Health Alliance Individual Plans.

To sign up for auto pay from your checking or savings account, please complete **Option A** below and return it in the provided envelope.

- **Set up monthly auto pay** from your checking or savings account. See Option A for details.
- **Set up a recurring transaction** to your credit card. See Option B.
- **Pay online** using a credit card, debit card or an e-check using your bank account. Log in at YourHealthAlliance.org for more details.
- Receive and pay a monthly statement **by mail**.

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 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 _____

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 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: _____