Plans are provided by Medica Central Health Plan

Medica CW199IFB
PO Box 9310
Minneapolis, MN 55440-9310

phone: 877-379-7599

TTY: 711

Or, fax it to: 952-992-2851

Authorization for Recurring Automatic ACH Debits

Medica ("we", "us", and "our) has extended you, the person signing this authorization form ("you" and "your"), a health insurance policy.That health insurance policy is governed by the terms of your policy of coverage.

Service. We offer you an easy way to make monthly premium payments.This payment service allows us to automatically deduct funds by Automated Clearing House (ACH) debit from your checking or savings account on a monthly basis to pay your monthly premiums. This can ensure your monthly premiums will be paid in a timely manner even if, for example, you are traveling. There is no cost to you for this service.

Instructions. Simply sign this authorization and attach a voided check that shows the bank routing and account number and mail the signed authorization and voided check to the address listed on the back of the page.Please be sure to fill in the form below, including your financial institution name, routing number and account number. We must receive this form within seven business days of the withdrawal date (as defined below) or you will need to make alternate arrangements to pay your current premium due.

Authorization. By signing below, you authorize us to electronically debit the amount of your monthly premium from your account (as defined below) on a recurring monthly basis without any further affirmative action on your part to initiate each such future debit. Each debit will be in the amount of your monthly premium that is disclosed in your statement then in effect. Your account to be debited is designated below by you (the "account"). If you have already paid your first health insurance premium, we will debit your next payment on or after the 23rd of the month following our receipt of this authorization form from you. If you provide us your email address, we will send you an email confirmation prior to the first withdrawal date notifying you of the initial debit amount and when the first debit will occur.

If you have not made your first health insurance monthly premium, you authorize us to electronically debit the amount that is set forth in the Coverage Pending Letter from your account and that payment will be processed upon the receipt of this authorization form to activate your coverage. Thereafter, we will debit your monthly premium on the 23rd of each month, or the following business day if the 23rd is not a business day (the "withdrawal date") in accordance with the instructions in the preceding paragraph.

Returned Payments. If your payment is returned unpaid for any reason, you are responsible for payment of the monthly premium within the grace period described in your policy of coverage to avoid termination of your "insurance policy" for non-payment of the premium.

Errors. You further authorize us to electronically debit or credit your account to correct any erroneous debit. Also, if there is any missing or erroneous information regarding your account, you authorize us to verify and correct the information.

Stopping Automatic Debits. You understand that this authorization will remain in full force and effect until you notify us that you wish to stop automatic debits. You understand that you must notify us at least seven (7) business days before the next scheduled withdrawal date in order to stop that debit. In order to notify us that you wish to stop automatic debits, you must log into our member portal at www.medica.com/login or contact our call center at 877-379-7599. If you stop automatic debits, you are responsible for making your payment of the monthly premium by the due date, by another payment method we agree to accept from time to time.

Miscellaneous. You agree that ACH transactions you authorize must comply with all applicable laws. You acknowledge your designated account is a legitimate, open, and active account and that you are an authorized signatory on the account. You agree to retain a copy of this authorization for your records, and you acknowledge that you may request an additional copy of this authorization from us by logging into our member portal or contacting our call center. You understand that the member portal and call center are provided by our agent, Medica.

Visit our secure payment website to make a one time payment central.medica.com

Want to set up automatic payment electronically go to central.medica.com

Please return the completed form to:

Medica CW199IFB
PO Box 9310
Minneapolis, MN 55440-9310

Name:			Date of birth:
Subscription ID (if known): Phone number:		Group/Policy:	IFB
Address 1:			
Address 2:			
City:		State:	ZIP:
Email address:			

Name of Account Holder	(please print)									Name of Financial Institution	
Routing number:										Type: ___ Checking ___ Savings	
Account number:											

Signature of Applicant Date (mm/dd/yyyy)