Automatic Premium Withdrawal Authorization

Medica

Please contact Medica Central Health Plan if you need information in another language or format (such as Braille).

Automatic Premium Withdrawal
Medica Central Health Plan provides the convenient option to have your premium amount automatically withdrawn from your checking or savings account each month. This ensures your premium is paid on time, without you ever having to worry about it. There is no extra cost to you for this service.

How do I sign up?
It's simple. To participate, please fill out the form below and include either a voided check or the account number and routing information for your checking or savings account.

How does it work?
Premiums are deducted on or after the 23rd of each month prior to the month of coverage. We will never change the amount of the premium without informing you.

When can I expect it to begin?
Please allow up to 10 business days for your authorization form to be processed. The first withdrawal will take place on the next regularly scheduled withdrawal date. If you're returning this form with a Medicare Advantage application, your automatic payments will start with your first payment.

What if I have other questions?
If you have any questions please call Member Services at **1 (877) 301-3326** (TTY: **711**).

What do I do with the form?
Please return this form with your billing statement along with your Medicare Advantage application. Or mail to:
Medica Enrollment
PO Box 852219, Richardson, TX 75085-9843

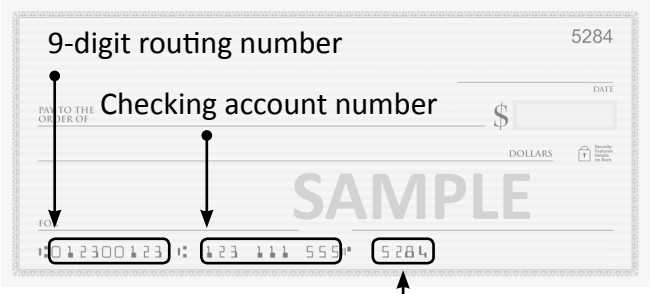
Last name	**First name**	**Middle initial**

Address, city, state, ZIP	**Member number** (if you have one)

Please select one of the following options:

☐ **I have enclosed a voided check.**

☐ **I will provide bank account information.**



Bank name: _____

9-digit routing number: _____

Account number: _____

Type of account (select one)**:** ☐ **Checking** or ☐ **Savings** (Your savings account number can be found on a bank statement or by contacting your bank.)

By the authorized bank account holder signature below, I authorize Medica Central Health Plan to instruct my financial institution to deduct my premium payments from the account designated above. I authorize the financial institution to debit the amount of my premium from my designated account. This authorization is to remain in full force and in effect until I send written notification to Medica Central Health Plan of my termination in such time and in such manner as to afford Medica Central Health Plan and the financial institution a reasonable opportunity to act on it.

Authorized bank account holder signature _____