Automatic Payment Authorization Form

SANFORD HEALTH PLAN

Member/Group Name: _____

DOB (if applicable): _____

Member or Group ID Number: _____

Phone Number: _____

PO Box 91110, Attn: Premium Billing
Sioux Falls, SD 57109-1110
(888) 845-4468 | TTY: 711
Fax: 605-328-6812
Email:
SHPBillingandEnrollment@SanfordHealth.org

Instructions:

Please complete the information below and return this form with a voided check or savings deposit slip to the address above. If emailing or faxing, a scanned copy of this form and a scanned copy of the voided check or savings deposit slip is acceptable. Please include payment for the current month's premium (if due) when returning this form.

Withdrawal dates:

- 5th of each month for Medicare Advantage policies, for group policies, and for other clients
- 10th of each month for policies purchased through an agent or direct from Sanford Health Plan
- 20th of each month for Marketplace (ACA Exchange) policies

By signing below, I acknowledge and understand:

- Sanford Health Plan will withdraw the health insurance premium due on the date specified above.
- If any past due premium is owed, the entire balance due with be withdrawn.
- All payments made via automatic payment will be applied to the oldest balance due.
- If I want to cancel this automatic withdrawal, I must notify Sanford Health Plan by phone at least **5 days** prior to the scheduled withdrawal.
- If my payment is returned, automatic withdrawals will be stopped until I notify Sanford Health Plan. Other payment arrangements must be made for any past due amounts prior to reinstatement of automatic payments.

For Marketplace polices only:

I also acknowledge and understand:

- If I receive a subsidy or changes are made to my plan, which the monthly withdrawal amount may change as the Marketplace (ACA Exchange) notifies Sanford Health Plan of the amount due each month.
- If Sanford Health Plan is notified of a subsidy amount change (if applicable) after the 15th of each month, additional funds may be owed or due. If this occurs, the amount withdrawn on my due date will be adjusted and include any credit or additional amount owed.

For Groups only:

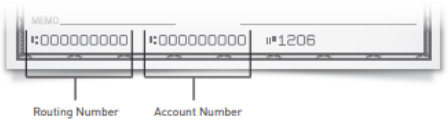
If you are a new group to Sanford Health Plan, please use the receipt of a premium invoice as an indicator that your first automatic draft will post on time. If you do not receive an invoice around the 20th, your first and second month's premiums will be drafted on the 5th of the following month.

I **authorize Sanford Health Plan to initiate monthly, electronic debit entries to the bank account as shown below. This Automatic Payment Authorization Form will remain in force until Sanford Health Plan is contacted as outlined above.**

Bank Name _____ **□ Checking Account □ Savings Account**

Bank Address _____

Routing Number _____ **Account Number** _____



Member or Employer Name (please print) _____

Signature _____ **Date** _____