



1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
(877) 509-4979 | TTY 711

Medicare Advantage

Automatic Premium Payment Plan

For your convenience, you may have your monthly premium payments made automatically from your checking/savings account or by debit/credit card. This automatic plan provides an easy, dependable way to make premium payments.

- Please allow up to 60 days for your authorization form to be processed and your first automatic payment to be deducted.
- We will notify you when you can expect your payments to begin.
- Your premium will be deducted on the 20th of the month preceding the month of coverage.
- If the amount of your premium changes you will be informed in advance.
- If you have any questions please call our Customer Service Department at (877) 509-4979 (TTY 711). We are open 7 days a week, 8 a.m. to 8 p.m., from Oct. 1 – March 31; and Monday through Friday, 8 a.m. to 8 p.m., from April 1 – Sept. 30.

You can sign up for an automatic premium payment plan by completing one of the forms below, detach and return it with your new application or mail to: **Attn: ACH Department, Align powered by Sanford Health Plan (PPO), PO Box 8000 Marshfield, WI 54449-8000**. Or you can sign up through your secure member portal after your policy becomes effective.

Automatic Premium Payment Authorization		
Subscriber name (last, first, middle initial)	Financial institution of payor <i>(see sample below when completing 1 – 5)</i>	
Mailing address	1 Name	
Phone ()	2 Branch	
Make this deduction from: ☐ Checking (enclose voided check) ☐ Savings (indicate account number) _____	3 Address	
	4 ABA routing number	5 Account number

I (payor) authorize Align powered by Sanford Health Plan and the financial institution named above to initiate entries to my checking/savings account for payment of premiums. This authority will remain in effect until I notify you (Plan) and the financial institution to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I understand the premium will be deducted on or after the 20th of the month. I can stop payment of any entry by notifying you and my financial institution seven days before my account is charged. I understand the amount of an erroneous charge will be credited to my account upon notification.

_____/_____/_____
Payor signature Date (m/d/y) Subscriber signature (if not payor) Date (m/d/y)

John Doe 123 Main Street Anywhere, USA 12345		1234
DATE _____		
PAY TO THE ORDER OF _____		\$ []
_____ DOLLARS		1
Your Bank Name ① Bank Branch ② 987 High Street ③ Anytown, USA 56789		
MEMO _____		
④	⑤	
1 2 3 4 5 6 7 8 9	9 8 7 6 5 4 3 2 1	1 2 3 4

Credit/Debit card payment method (We accept Visa, MasterCard and Discover)

Name on card

Card number

Card security code (3-digit
code on back of card)

Expiration date (mm/yy)

Billing address

City

State

ZIP code

I hereby authorize Align powered by Sanford Health Plan and Chase Paymentech Services to initiate a debit to my credit or debit card for payment of premiums. I understand that this authorization is to remain in effect unless I notify Align powered by Sanford Health Plan and the financial institution of a change within a time and manner as to afford Align powered by Sanford Health Plan and the financial institution a reasonable opportunity to act on it.

Payor signature

____/____/____
Date (m/d/y)**Notice of nondiscrimination**

Align powered by Sanford Health Plan is a PPO plan with a Medicare contract. Enrollment in Align powered by Sanford Health Plan depends on contract renewal. Sanford Health complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Language assistance services

English: Free interpretation services are available to you. Additional services and resources necessary to provide information on accessible formats are also available at no cost. Call (877) 509-4979 (TTY 711) or speak with your healthcare provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al (877) 509-4979 (TTY 711) o hable con su proveedor.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie (877) 509-4979 (TTY 711) an oder sprechen Sie mit Ihrem Provider.

Oromo: HUBADHAA: Yoo afaan Oromoo dubbattu ta'e, tajaajilli gargaarsa afaanii bilisaa siniif ni argama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbilaa (877) 509-4979 (TTY 711) yookiin dhiyeessaa kee waliin haasa'aa.

Large print – If you require materials in large print, please call (877) 509-4979 (TTY 711).