Automatic Payment Authorization Form

Align powered by Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110
Phone (888) 278-6485

Member/Group Name: _____ **DOB (if applicable):** _____

Member or Group ID Number: _____ **Phone Number:** _____

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

By signing below, I acknowledge and understand:

- Align powered by 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- If any past due premium is owed, the entire balance due with be withdrawn.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 Align powered by 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 Align powered by Sanford Health Plan. Other payment arrangements must be made for any past due amounts prior to reinstatement of automatic payments.

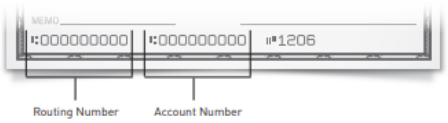
I **authorize Align powered by Sanford Health Plan to initiate monthly, electronic debit entries to the bank account as shown below. This Automatic Payment Authorization Form will remain in force until Align powered by Sanford Health Plan is contacted as outlined above.**

Bank Name_____ □ **Checking Account** □ **Savings Account**

Bank Address _____

Routing Number _____

Account Number_____



Member Name (please print) _____

Signature _____ **Date** _____