ASPIRUS HEALTH PLAN

PAYMENT AUTHORIZATION FORM

ACCOUNT HOLDER INFORMATION:

Name _____

Subscriber Number (if available)_____Social Security Number _____- _____-_____

Mailing Address: Street/P.O. Box _____

City _____ State_____ ZIP_____County_____

AUTOMATIC WITHDRAWAL:

Select One: ❑ Checking Account ❑ Savings Account

Routing Number _____ Account Number _____

Bank Name _____

By my signature below, I authorize the Insurer to instruct my financial institution to deduct my premium payments from the account designated above. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify the Insurer in writing of its termination. My notification must afford the Insurer and my financial institution reasonable opportunity to act on it.

Note: Recurring premium payments will be charged to your checking/savings account on the first business day of each month. We will continue to charge premiums until the policyholder notifies us to discontinue charging premiums in accordance with the Insurer's policy.

SIGN HERE ⇨ _____ _____

Applicant's Signature *Date*

SIGN HERE ⇨ _____ _____

Account Holder (if different from Applicant) *Date*

MAIL PAYMENT TO:

Aspirus Health Plan
PO Box 851372
Minneapolis, MN 55485-1372

PLEASE EMAIL THIS SIGNED AND COMPLETED FORM TO **Finance@AspirusHealthPlan.com**
OR FAX THIS SIGNED AND COMPLETED FORM TO **763.847.4010**

FINANCIAL INFORMATION