



Dear Member:

We are pleased to offer automatic payment as a method to pay your monthly Aspirus Health Plan premium. This paperless service that is convenient, reliable, and safe. This option ensures that your health plan premium is always paid on time – no postage necessary! And record keeping is easy – your bank statement shows all automatic payment deductions, and serves as proof of payment.

Automatic payment allows your plan premium to be automatically deducted from your checking or savings account between the 7<sup>th</sup> and 10<sup>th</sup> days of each month.

To enroll, your account must be paid up through your current billing statement. Please complete, sign, and send us the Automatic Payment Form below along with:

- A voided check to have your monthly payment deducted from your checking account; or
- A savings account deposit slip to have your monthly payment deducted from your savings account; or
- Provide your banking information on the form below.

**Automatic Monthly Payment Terms and Conditions:**

- Aspirus must receive this form 30 days prior to the start of monthly deductions.
- This agreement will remain in effect until you notify Aspirus that you wish to cancel the automatic payment.
- Requests to cancel must be received by Aspirus 15 days prior to the deduction date.

Please mail your completed form and voided check or savings account deposit slip to:

Aspirus – ATTN: Membership Billing, P.O. Box 51, Mpls, MN 55440-0051.

If you have any questions, please contact Customer Services at the number on the back of your member ID card.

Best Regards,

Aspirus Health Plan

## Automatic Payment Form

**Aspirus Member ID:**

- Checking account** (please attach a voided check or print your account information below – we cannot accept a checking account deposit slip).

**Bank Routing Number (9 digits):**

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**Your Checking Account Number:**

- Savings account** (please attach a savings account deposit slip or print your account information below)

**Bank Routing Number (9 digits):**

\_\_\_\_\_

**Your Bank Account Number:**

- By checking this box I give Aspirus permission to pull my total balance due with my first automatic payment deduction. This includes any past due balance that I owe to Aspirus and may exceed my usual monthly premium amount. Leaving this box unchecked means that I will be responsible to initiate payments for other outstanding balances.

I authorize Aspirus to set up my account with automatic monthly plan premium payments as directed above. By signing this form, I understand and accept the terms and conditions associated with this form (please read the terms and conditions on the back of this form).

**Member Signature:**

**Date:**

**Member Phone:**

**Bank Name:**

## **Notice of Nondiscrimination**

Aspirus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aspirus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **715-631-7411 (voice)** or toll free at **1-855-931-4850 (voice)**, **715-631-7413 (TTY)**, or **1-855-931-4852 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**.

If you believe that Aspirus Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

### Oral grievance

If you are a current Aspirus Health Plan member, please call the number on the back of your membership card. Otherwise please call **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

### Written grievance

#### *Mailing Address*

Attn: Appeals and Grievances

Aspirus Health Plan

P.O. Box 51

Minneapolis, MN 55440

Email: [cagMA@aspirushealthplan.com](mailto:cagMA@aspirushealthplan.com)

Fax: 715-631-7439

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

