Individual Payment Authorization Form

Return completed, signed form to: Aspirus Health Plan, ATTN: Finance, PO Box 1890 Southampton, PA 18966-9998
or email to: Finance@aspirushealthplan.com. If you have questions, please call Customer Service at: 866.631.5404.

ACCOUNT HOLDER INFORMATION

Account Holder Name	Subscriber Number *(if available)*	Social Security Number

Account Holder Street Address	City	State	Zip Code

AUTOMATIC WITHDRAWAL

Please include a voided check or confirmation of account information on bank letterhead with this form.

Name on Account

Bank Name

Bank Street Address	City	State	Zip Code

Routing Number	Account Number	Type of Account *(check one)*
		☐ Checking ☐ Savings

NOTE: *Recurring premium payments will be charged to your account on the first of the month. We will continue to charge premiums until the policyholder notifies us to discontinue charging premiums in accordance with the Insurer's policy.*

Credit Card Authorization

☐ **AUTHORIZATION VIA CREDIT CARD - CREDIT CARD TYPE** *(Check one):* ☐ **Visa** ☐ **MasterCard** ☐ **Discover**

Name as it appears on card

Street Address	City	State	Zip Code

Credit Card Number	CVV# (on back of card)	Expiration Month/Year

AUTHORIZATION

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.

Applicant's Signature	Date
X	

Account Holder Signature *(if different from Applicant)*	Date
X	