



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			
<i>Please include a voided check or confirmation of account information on bank letterhead with this form.</i>			
Name on Account			
Bank Name			
Bank Street Address	City		State
		Zip Code	
Routing Number	Account Number		Type of Account (check one)
			<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Recurring Payment withdrawal date: <input type="checkbox"/> First day of the month <input type="checkbox"/> 20th day of the month prior NOTE: Recurring premium payments will be charged to your checking/savings account based on your selection above. We will continue to charge premiums until the policyholder notifies us to discontinue charging premiums in accordance with the Insurer's policy. If you do not choose a day, the payment pull will occur on the 20th of the month prior to the payment due date.			
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			