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

AUTOMTIC 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	

Recurring Payment withdrawal date: ☐ First day of the month ☐ 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	