*Please write the subscriber's name on the top of pages two and three.



PREMIUM PAYMENT OPTIONS

Select how you'd like to pay your first month and/or ongoing premium payments and complete the information below.

You also may pay your premium and sign up for the automated payment plan online at **Medica.com/payments**.

Please PRINT CLEARLY in UPPERCASE LETTERS blue or black ink.

Return completed form to:

Medica CW199IFB PO Box 9310

Minneapolis, MN 55440-9310

Or, fax it to: 952-992-2851

SUBSCRIPTION INFORMATION					
Name:	Date of birth:				
Subscription ID (if known):	Group/Policy: IFB				
Phone number:					
Address 1:					
Address 2:					
City:					
State: ZIP:					
Email address:					
Note: Your email address will be used to confirm your enrollmen	t in automatic payments and to communicate the amount and				
date of when Medica will withdraw your next payment.					
OPTION 1: ELECTRONIC PAYMENT FROM A CHECKING	ACCOUNT				
Complete the information below to make your payment(s) electr	onically through a checking account.				
Name on account: First name Middle init	ial Last name				
Bank name: Amount \$:					
Bank routing #: Bank account #	State:				
YOUR NAME IS					
Refer to the image to locate the bank routing and account					
number. Do not include the check number as part of the					
routing or account number.					
ROUTING ACCOUNT CHECK					
Please use the banking information above to pay for:					
☐ First month premium payment only					
☐ First month and ongoing automatic premium payments* ☐ Ongoing automatic premium payments only*					
I understand by signing this form, I am giving Medica and the bank named above permission to withdraw payment(s) from my bank account as indicated above. If you are not the health plan subscriber, check here					

BILIFB10504-1-00222 continues on next page... Page 1 of 3

^{*}Please see Important Notice for Automatic Monthly Payments on page 3.

Name:	ID:		⊗ Medica	
OPTION 2: ELECTRONIC PAYMENT FROM A	SAVINGS ACCOUNT			
Please complete the information below to make yo			account.	
Name on account: First name	Middle initial Last name			
] [
		- 1		
Bank name:		Amount \$:		
Bank routing #: Ba	nk account #:		State:	
FOUNDS ACCOUNT CHECK NUMBER NUMBER	number. D	ne image to locate the bank r to not include the check num account number.	_	
Please use the banking information above to pay f	or:			
☐ Ongoing automatic premium payments only*	Note: Be sure to selec	t an option for your first mo	nth premium payment.	
I understand by signing this form, I am giving Medic bank account as indicated above. If you are not the			payment(s) from my	
Signature of bank account holder	re of bank account holder Signature of bank account holder (if joint account)			
X	X			
OPTION 3: CREDIT OR DEBIT CARD PAYME	NT			
Please complete the information below to make yo	ur payment(s) by a credit	or debit card.		
Name on account: First name	Middle initial	Last name		
Card type:		Amount \$:		
Card number:		Expiration Date:	Security Code:	
	-			
Please use the card information above to pay for:				
lue First month premium payment only				
☐ First month and ongoing automatic premium payments* ☐ Ongoing automatic premium payments only*				
I understand by signing this form, I am giving Medic health plan subscriber, check here \Box	a permission to charge m	ny credit card as indicated ab	ove. If you are not the	
Signature of cardholder				
X				

BILIFB10504-1-00222 continues on next page... Page 2 of 3

^{*}Please see *Important Notice for Automatic Monthly Payments* on page 3.

Name:	ID:	——— ⊗ Medica	
OPTION 4: CHECK OR MONEY			
	low to make your payment(s) with a check or	money order.	
Please use the banking information	above to pay for:		
☐ First month premium payment (i	nclude check or money order with this form)		
☐ Ongoing premium payment (we'	I mail you an invoice each month)		
Amount \$:			
Please make your check or money o	order payable to Medica. If you are not the h	ealth plan subscriber, check here 📮	
Note: Only include a check or money order with this form if you're paying for your first month's premium payment.			
	Attach check(s) here		

*IMPORTANT NOTICE FOR AUTOMATIC MONTHLY PAYMENTS:

This agreement will remain in effect until you notify Medica and your bank in writing to cancel it. If you wish to stop automatic payments, you must notify Medica seven business days prior to the month your premium is due.

Attention: If you'd like your automatic payments to be applied to your current bill, please enroll before the last 2 days of the month. If you submit your request during the last 2 days of the month, you will need to make a one-time payment for the current balance due.

If the necessary funds are not in your account the day Medica withdraw the payment, we will send you an invoice for the past due premium. You must pay this amount to avoid termination of your policy. You will be liable for any expenses Medica may incur following your termination date if termination results from non-payment.

Page 3 of 3