



Medica CW199IFB  
PO Box 9310  
Minneapolis, MN 55440-9310  
phone: 866-394-6877  
TTY: 711  
Or, fax it to: 952-992-2851

## Authorization for Recurring Automatic ACH Debits

Medica, Inc. ("we", "us", and "our") has extended you, the person signing this authorization form ("you" and "your"), a health insurance policy. That health insurance policy is governed by the terms of your policy of coverage.

**Service.** We offer you an easy way to make monthly premium payments. This payment service allows us to automatically deduct funds by Automated Clearing House (ACH) debit from your checking or savings account on a monthly basis to pay your monthly premiums. This can ensure your monthly premiums will be paid in a timely manner even if, for example, you are traveling. There is no cost to you for this service.

**Instructions.** Simply sign this authorization and attach a voided check that shows the bank routing and account number and mail the signed authorization and voided check to the address listed on the back of the page. Please be sure to fill in the form below, including your financial institution name, routing number and account number. We must receive this form within seven business days of the withdrawal date (as defined below) or you will need to make alternate arrangements to pay your current premium due.

**Authorization.** By signing below, you authorize us to electronically debit the amount of your monthly premium from your account (as defined below) on a recurring monthly basis without any further affirmative action on your part to initiate each such future debit. Each debit will be in the amount of your monthly premium that is disclosed in your statement then in effect. Your account to be debited is designated below by you (the "account"). We will debit your first payment on or after the 1st of the month following our receipt of this authorization form from you. If you provide us your email address, we will send you an email confirmation prior to the first withdrawal date notifying you of the initial debit amount and when the first debit will occur. Thereafter, we will debit your monthly premium on the 1st of each month, or the following business day if the 1st is not a business day (the "withdrawal date").

**Returned Payments.** If your payment is returned unpaid for any reason, you are responsible for payment of the monthly premium within the grace period described in your policy of coverage to avoid termination of your "insurance policy" for non-payment of the premium.

**Errors.** You further authorize us to electronically debit or credit your account to correct any erroneous debit. Also, if there is any missing or erroneous information regarding your account, you authorize us to verify and correct the information.

**Stopping Automatic Debits.** You understand that this authorization will remain in full force and effect until you notify us that you wish to stop automatic debits. You understand that you must notify us at least seven (7) business days before the next scheduled withdrawal date in order to stop that debit. In order to notify us that you wish to stop automatic debits, you must log into our member portal at [www.medica.com/memberlogin](http://www.medica.com/memberlogin) or contact our call center at (866)-394-6877. If you stop automatic debits, you are responsible for making your payment of the monthly premium by the due date, by another payment method we agree to accept from time to time.

**Miscellaneous.** You agree that ACH transactions you authorize must comply with all applicable laws. You acknowledge your designated account is a legitimate, open, and active account and that you are an authorized signatory on the account. You agree to retain a copy of this authorization for your records, and you acknowledge that you may request an additional copy of this authorization from us by logging into our member portal or contacting our call center. You understand that the member portal and call center are provided by our agent, Medica.

Visit our secure payment website to make a one time payment [Medica.com/PayPremium](https://www.Medica.com/PayPremium)

Want to set up automatic payment electronically go to [Medica.com/PayPremium](https://www.Medica.com/PayPremium)

Please return the completed form to:

Medica CW199IFB  
PO Box 9310  
Minneapolis, MN 55440-9310

Name:		Date of birth:	
Subscription ID (if known):		Group/Policy:	IFB
Phone number:			
Address 1:			
Address 2:			
City:		State:	ZIP:
Email address:			

Name of Account Holder	(please print)	Name of Financial Institution
Routing number:		Type: ___ Checking ___ Savings
Account number:		

Signature of Applicant

Date (mm/dd/yyyy)



