Medica Prime Solution® (Cost) and Medica Group Prime Solution℠ (Cost)

2024 Electronic Funds Transfer Form (EFT)

A	PLEASE READ BEFORE COMPLETING YOUR FORM

Automatic premium payment is a safe, worry-free way to ensure that your premium payments are received on time. **If you sign up for automatic payment of your Medica premium, payments will be transferred from your bank account on the fifth business day of each month**. The fund transfer is conducted using the Automated Clearing House (ACH) system, a fund transfer system with national rules, standards and procedures that is widely used by financial institutions across the country.

Complete this form and send to Medica along with either a voided check if you want your premiums deducted from your checking account, or a savings deposit slip if you want the premium deducted from your savings account. In order for the automatic payment option to be activated, Medica must receive this form at least 30 days prior to the start of the month you would like automatic payments to begin. The automatic payment fund transfer will then remain in effect until you notify Medica to cancel it. If you want to cancel automatic payment, Medica must receive your request at least five business days prior to the next scheduled withdrawal date. When making a plan change, your premiums and automatic payment will be adjusted accordingly.

Please send your completed form with your voided check or savings deposit slip.

Mail	Fax
Automatic Payment Plan Medica PO Box 740110 Atlanta, GA 30374-0110	1 (855) 250-2166

If you have questions concerning automatic premium payment, please call Medica Billing at **1 (866) 269-6804** (TTY: **711**) from 7 a.m.-6 p.m. CT, Monday-Friday.

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1	PERSONAL INFORMATION		
	Legal First Name	Middle Initial	Last Name
	Medicare Number		Birthdate _ _ _ _ / _ _ _ _ / _ _ _ _ _ _ _ _ (M M / D D / Y Y Y Y)
	Primary Telephone (*With area code)* (_____) _____ - _____ _	Financial Institution Name	
	Please deduct my monthly premium from: ❍ Checking Account — **Attach a voided check** ❍ Savings Account — **Attach a deposit slip**		

2	BANK INFORMATION
	I authorize Medica and the Bank named above to initiate monthly withdrawals from my checking or savings account, as indicated. This agreement will remain in effect until I notify Medica to cancel it. I understand that I will receive a letter from Medica stating the effective date of my automatic payment once my application has been processed.
	_____ _ _ _ _ / _ _ _ _ / _ _ _ _ _ _ _ _ Bank Account Holder Signature (M M / D D / Y Y Y Y) Agent's Receipt Date
	The information below is required if the member/enrollee is not the bank account holder:
	X _____ (_ _ _) _ _ _ - _ _ _ _ _ _ _ Bank Account Holder Name Bank Account Holder Telephone
	Note: By this authorization, I understand that if the necessary funds are not present in my account on the designated day for automatic payment, Medica will send me a balance due letter for the past due premium. This premium must be paid in order to avoid termination of my policy. I understand that I will be liable for any expenses Medica may incur following my termination date if termination results from my non-payment.

Medica®

PO Box 9310, Minneapolis, MN 55440-9310