Health Plus

SCOTT & WHITE HEALTH PLAN

Commitment to Pay Premiums Electronically (e-Pay or Bank Draft)

I understand as agreed in the Evidence of Coverage, that all premiums are due in the office of the Health Plan on or before the 1st day of each month. The Contract Holder is responsible for remitting all premiums due under this Agreement to Health Plan when due; therefore, I hereby agree to pay my Health Plus premiums electronically. I agree these payments will be made by the 1st day of the month for coverage effective the first of the month.

By agreeing to use one of the methods of electronic payment below, I understand that I am eligible to receive a discount on my monthly premium. **If I choose to no longer pay my premiums electronically, I will not be eligible for the discounted premium rate and my account will be adjusted to reflect the non-discounted rate.**

I choose to pay by:

_____**Online (e-Pay)** by accessing the Scott & White Health Plan website at www.swhp.org.

_____**Bank Draft** (Enclose a voided check and fill in the financial institution information)
(Please note: Bank drafts occur between the 15th and 20th of the month.)

For Bank Draft - please read the following and fill out the financial institution information below:
I hereby authorize the Health Plan to initiate debit entries to my financial institution account indicated below at the financial institution named below and to debit the same to such account. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until the Health Plan has received written notification from me of its termination in such time and in such manner as to afford the Health Plan and my financial institution a reasonable opportunity to act on it.

Financial Institution Name: _____

Routing Number: _____ Account Number: _____
Type of financial institution account: ☐ Checking Account ☐ Savings Account

If any ACH transaction does not clear my account on the first attempt, I will be notified and given a deadline to make the payment. Multiple returned payments can result in the loss of the eligibility to pay electronically or the termination of coverage. I understand that not paying premium by the due date can result in termination of coverage.

_____
Contract Holder Name Printed Contract ID Number

_____
Contract Holder Signature Date

_____ _____
Authorized Signature for Account (If different than Contract Holder) Date

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FOR OFFICE USE ONLY

Draft Effective Date _____ Submitted by_____