



Please complete this form and either return it with your enrollment application in the enclosed envelope or mail it to:

UPMC Health Plan
 Premium Billing Department
 One Chatham Center
 112 Washington Place
 Pittsburgh, PA 15219

PAYMENT ELECTION FORM

Member Name: _____ Member ID Number: _____
 (Number on your UPMC Health Plan ID Card, if known)

I hereby authorize UPMC Health Plan, its affiliates, and subsidiaries to deduct insurance payments from my account at the financial institution named below:

Select either a checking/saving or credit card option (choose only one option):

Checking/Saving Options:

Banking or Financial Institution Name: _____

Checking Account Savings Account Credit Union Share Draft Account

- Please submit a voided or photocopied check with this authorization form.
- If the voided check or deposit slip does not include transit or account numbers, please obtain this information from your financial institution and submit it with this authorization form.

Credit Card Options:

Visa MasterCard Discover American Express

Account Number: Expiration Date: _____

Zip Code of Credit Card Account Holder (required for security purposes): _____
 (This is the zip code where you receive your bill.)

If we receive this form by the 25th of the month, your first payment will be deducted on the 5th of the following month. If we receive it after the 25th of the month, then the automatic payment deduction will be delayed by an additional month. UPMC Health Plan will deduct the premium amount from your account on the 5th, unless the 5th is a weekend or holiday; then we will deduct the premium the next business day. This agreement is to remain in effect until UPMC Health Plan has received written and signed notification from me of its termination in such time and in such manner as to afford UPMC Health Plan and the depository institution a reasonable opportunity to act on the request.

If any deduction is not honored by my bank, the policy will be considered not paid. UPMC Health Plan will ask me to pay the dishonored amount. After timely payment is received by UPMC Health Plan, deductions will resume. UPMC Health Plan has the right to discontinue the Pre-Authorization Payment Plan if one automatic deduction is not honored.

UPMC Health Plan will notify me in advance whenever the deduction amount or deduction day changes via the monthly invoice. UPMC Health Plan may revise the terms of this agreement at any time upon written notification.

_____ Print Name of Checking/Banking or Credit Card Holder (As it appears on your account)	_____ Print Name of UPMC Health Plan Member (If different from name of Banking or Credit Card Holder)
_____ Signature of Banking or Credit Card Holder (As it appears on your account)	_____ Date