

# Automatic Payment Authorization Form



Member/Group Name: \_\_\_\_\_

DOB (if applicable): \_\_\_\_\_

Member or Group ID Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

PO Box 91110, Attn: Premium Billing

Sioux Falls, SD 57109-1110

(888) 845-4468 | TTY: 711

Fax: 605-328-6812

Email:

[SHPBillingandEnrollment@SanfordHealth.org](mailto:SHPBillingandEnrollment@SanfordHealth.org)

## Instructions:

Please complete the information below and return this form with a voided check or savings deposit slip to the address above. If emailing or faxing, a scanned copy of this form and a scanned copy of the voided check or savings deposit slip is acceptable. Please include payment for the current month's premium (if due) when returning this form.

## Withdrawal dates:

- 5<sup>th</sup> of each month for Medicare Advantage policies, for group policies, and for other clients
- 10<sup>th</sup> of each month for policies purchased through an agent or direct from Sanford Health Plan
- 20<sup>th</sup> of each month for Marketplace (ACA Exchange) policies

## By signing below, I acknowledge and understand:

- Sanford Health Plan will withdraw the health insurance premium due on the date specified above.
- If any past due premium is owed, the entire balance due will be withdrawn.
- All payments made via automatic payment will be applied to the oldest balance due.
- If I want to cancel this automatic withdrawal, I must notify Sanford Health Plan by phone at least **5 days** prior to the scheduled withdrawal.
- If my payment is returned, automatic withdrawals will be stopped until I notify Sanford Health Plan. Other payment arrangements must be made for any past due amounts prior to reinstatement of automatic payments.

## For Marketplace policies only:

I also acknowledge and understand:

- If I receive a subsidy or changes are made to my plan, which the monthly withdrawal amount may change as the Marketplace (ACA Exchange) notifies Sanford Health Plan of the amount due each month.
- If Sanford Health Plan is notified of a subsidy amount change (if applicable) after the 15<sup>th</sup> of each month, additional funds may be owed or due. If this occurs, the amount withdrawn on my due date will be adjusted and include any credit or additional amount owed.

## For Groups only:

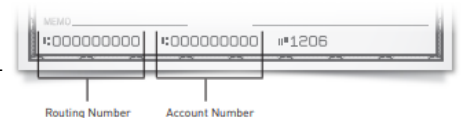
If you are a new group to Sanford Health Plan, please use the receipt of a premium invoice as an indicator that your first automatic draft will post on time. If you do not receive an invoice around the 20<sup>th</sup>, your first and second month's premiums will be drafted on the 5<sup>th</sup> of the following month.

I authorize **Sanford Health Plan** to initiate monthly, electronic debit entries to the bank account as shown below. This Automatic Payment Authorization Form will remain in force until Sanford Health Plan is contacted as outlined above.

Bank Name \_\_\_\_\_  Checking Account  Savings Account

Bank Address \_\_\_\_\_

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_



Member or Employer Name (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_