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You also may pay your premium and sign up for the automated payment plan								1	Medica CW199IFB PO Box 9310 Minneapolis, MN 55440-9310																					
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OPTION 2 Complete t Name on a	he info ccount	rmat		oelo	ow t						nent		elec	troni						ast r	iame	2								
Bank name																				Aı	nou	nt \$:								
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Refer to the image to locate the bank routing and account number. Do not include the check number as part of the routing or account number.																														
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*Please see *Important Notice for Automatic Monthly Payments* on page 3.

Name:	ID:		⊘Medica
OPTION 2: ELECTRONIC PAYMENT FROM	A SAVINGS ACCOUN	Г	
Please complete the information below to make yo	our ongoing payments ele	ectronically through a savir	ngs account.
Name on account: First name	Middle initial	Last name	
Bank name:		Amount \$:	
Bank routing #: Bank routing #:	ank account #:		State:
	number.	he image to locate the bar Do not include the check n r account number.	-
Please use the banking information above to pay Ongoing automatic premium payments only*		ct an option for your first i	month premium payment.
I understand by signing this form, I am giving Medi bank account as indicated above. If you are not the Signature of bank account holder	e health plan subscriber,	-	
х	х		
OPTION 3: CREDIT OR DEBIT CARD PAYMI	ENT		
Please complete the information below to make yo	our payment(s) by a cred	t or debit card.	
Name on account: First name	Middle initial	Last name	
Card type: 🛛 Visa 🖓 Mastercard		Amount \$:	
Card number:		Expiration Date:	Security Code:
	-		
Please use the card information above to pay for:			
First month premium payment only			
□ First month and ongoing automatic premium pa	ayments* 🗖 C	ngoing automatic premiur	n payments only*
I understand by signing this form, I am giving Medi health plan subscriber, check here	ica permission to charge	my credit card as indicated	above. If you are not the
Signature of cardholder			
x			

*Please see Important Notice for Automatic Monthly Payments on page 3.

ID:



OPTION 4: CHECK OR MONEY ORDER PAYMENT

Please complete the information below to make your payment(s) with a check or money order.

Please use the banking information above to pay for:

Girst month premium payment (include check or money order with this form)

Ongoing premium payment (we'll mail you an invoice each month)

Amount \$:

Please make your check or money order payable to Medica. If you are not the health plan subscriber, check here

Note: Only include a check or money order with this form if you're paying for your first month's premium payment.

Attach check(s) here

*IMPORTANT NOTICE FOR AUTOMATIC MONTHLY PAYMENTS:

This agreement will remain in effect until you notify Medica and your bank in writing to cancel it. If you wish to stop automatic payments, you must notify Medica seven business days prior to the month your premium is due.

Attention: If you'd like your automatic payments to be applied to your current bill, please enroll before the last 2 days of the month. If you submit your request during the last 2 days of the month, you will need to make a one-time payment for the current balance due.

If the necessary funds are not in your account the day Medica withdraw the payment, we will send you an invoice for the past due premium. You must pay this amount to avoid termination of your policy. You will be liable for any expenses Medica may incur following your termination date if termination results from non-payment.