AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWAL

Complete this form to have premium payments automatically deducted from your checking or savings account. **Submit one form for each applicant**.

1. Banking Information:

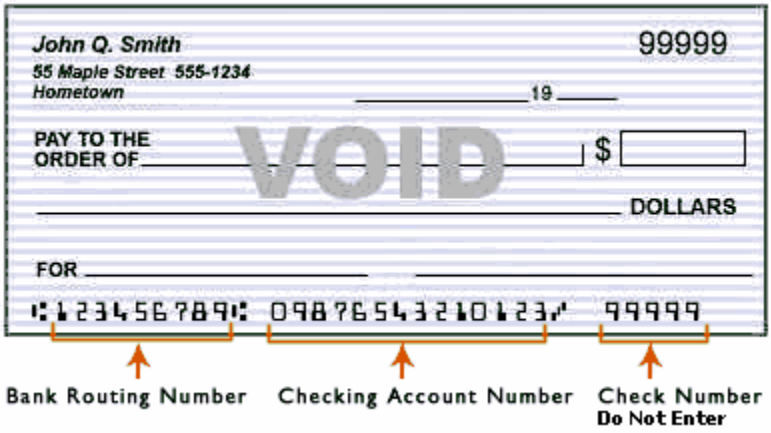
Applicant/Member Name		Account Holder Name		
Street Address	Unit	City	State	ZIP Code
Bank Name		Routing Number	Account Number	

2. Please deduct the monthly premium from (check one of the following):

☐ Checking Account
(MUST attach voided check)

☐ Savings Account
(MUST attach deposit slip)

SAMPLE CHECK



3. Authorize Withdrawal

I hereby authorize Providence Health Assurance-Medicare Supplement to withdraw from the above checking/savings account the amount necessary to pay the premium for *(applicant name)* _____. This authority will remain in effect until I notify Providence Health Assurance in writing to cancel, with enough time to allow the bank a reasonable opportunity to act on the cancellation. Furthermore, I certify that I am an authorized signer of this listed account according to the records of the financial institution listed above.

Please attach either a voided check for checking withdrawal or deposit slip for a savings withdrawal.

Name (please print) _____Date_____

Signature: _____

If you have any questions, please call Providence Health Assurance at one of the numbers below:
Local: (971) 345-4013
Toll Free: (888) 231-9287
TTY users should call 711. We are open 8:00am – 5:00pm PT Monday through Friday.

Please mail this form to:
Providence Health Assurance-Medicare Enrollment
PO Box 14590 Salem, OR 97309