

Group Health's Clear Care HMO & PPO

Transfer of Funds for Monthly Premium Payment

I hereby authorize Group Health Cooperative or Group Health Options, Inc. to initiate fund transfers from my depository financial institution (bank) account indicated below and authorize my bank to honor these transfers.

Subscriber name _____

Subscriber address _____

City _____ State _____ ZIP _____

Subscriber number _____ Group number _____

Bank name _____ Branch _____

City _____ State _____ ZIP _____

Bank account number _____ Bank routing number _____ Checking Savings

Name(s) listed on account _____

If you would like to cancel your transfer of funds, please check this box and sign below.

Please attach a VOIDED CHECK or SAVINGS DEPOSIT SLIP here.

I have read and understand the terms and conditions on the back of this form.

Signature of Bank Account Holder Date

Signature of Bank Account Holder Date

**When completed, please mail this copy to:
Medicare Enrollment ANB-2, P.O. Box 34255, Seattle, WA 98124**

Terms and Conditions of Agreement for Automated Payment Plan

1. I understand that this agreement will remain in effect until Group Health* has received written notice from me that it should be cancelled. Notice of cancellation must be received by Group Health by the thirteenth day of the month to cancel this agreement effective the first day of the following month.
2. I further understand that I have the right to stop payment of a transfer from my depository financial institution (bank) account to Group Health. Notice of stop-payment to my bank must be made at least three working days before the seventh working day of the month. This notice will automatically cancel this agreement.
3. If no funds are transferred from my bank account to Group Health due to insufficient funds, I understand that to keep this agreement in force my account will be debited for the balance due, on or before the next automatic withdrawal date.
4. I understand the amount of transfer will change at the annual rate renewal, and that notice of this annual monthly dues change will be mailed to the address of record thirty days prior to its effective date.
5. I understand that I will not receive notice of change in the amount of a transfer, which may vary from the previous month due to the addition or deletion of persons enrolled under this agreement.
6. I understand that if I transfer my current enrollment to a Group Health Cooperative or Group Health Options, Inc. employer group, this agreement is automatically cancelled.
7. I understand that if I transfer my current enrollment to another Group Health individual plan, this agreement is automatically cancelled, and I will be required to complete another Medicare Transfer of Funds for Monthly Premium Payment agreement.

Payment will be deducted between the seventh and tenth day of each month for the current month's premium.

I agree to indemnify and hold harmless Group Health, its officers, directors, employees, and agents, for any claims arising out of transfers or deductions from my account in accordance with this agreement.

*Group Health refers to Group Health Cooperative or Group Health Options, Inc.

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Keep this copy for your records.

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