Payment Option Form

Name:	**Medicare Number:**
Home Phone Number:	Date of Birth:
Permanent Street Address (P.O. Box is not allowed):	Apt. #

City:	County:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Street Address):

Street Address:	City:	State:	ZIP Code:

Paying Your Plan Premium

Please select a premium payment option.

☐ Pay via check. You will receive a paper bill each month between the 15th and 20th of each month indicating your balance due.

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a **VOIDED** check or provide the following.

Account Holder Name: ______________________ Account type: ☐ Checking ☐ Savings
Bank Routing Number: ______________________ Bank Account Number: ______________________

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

☐ Credit Card. Please Provide the following information. The monthly premium will be deducted around the 7th of each month.

Type of Card: ______________________ Account Holder Name: ______________________

Account Number: ______________________ Expiration Date: __________/__________

Please see other side

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information.

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

Relationship to Enrollee:

Please submit this form to:

Attn: Accounts Receivable
Network Health Medicare Advantage Plans
1570 Midway Pl.
Menasha WI 54952

1605-01-0418