*Please write the subscriber's name on the top of pages two and three.



PREMIUM PAYMENT OPTIONS											
Select how you'd like to pay your first month and/or ongoing premium payments and complete the information below. You also may pay your premium and sign up for the automated payment plan online at medica.com/payments. Please PRINT CLEARLY in UPPERCASE LETTERS with blue or black ink.			Me PO	Return completed form to: Medica CW199IFB PO Box 9310 Minneapolis, MN 55440-9310							
			Or,	Or, fax it to: 952-992-2851							
SUBSCRIPTION INFORMATION											
Name:			Da	te of l	oirth:						
Subscription ID (if known):				oup/P	olicy:	: IFB					
Phone number:											
Address 1: Address 2: City:											
State: ZIP: -											
Email address:									1		_
Note: Your email address will be used to confirm your enro	11		atic n			-				_	
amount and date of when Medica will withdraw your next p OPTION 1: ELECTRONIC PAYMENT FROM A CHECKING	payment.		iatic p	ayme	nts a	ind to	con	nmun	icate	the	
amount and date of when Medica will withdraw your next properties. OPTION 1: ELECTRONIC PAYMENT FROM A CHECKING Complete the information below to make your payment(s) electronic payment (s).	ACCOUN	T					con	nmun	icate	the	
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amount and date of when Medica will withdraw your next properties of the information below to make your payment(s) electrons are on account: Name on account: Bank name: Bank routing #: Bank account #:	Refer to the number. Do routing or a	e imago not iraccoun	e to lonclude at num	ng acc name amount cate to the colorer	the ba	ank rounumbe	uting er as	and a part o	ccour of the	tate:	

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

Name:	ID:		MEDICA.
OPTION 2: ELECTRONIC PAYMENT FRO	OM A SAVINGS ACCOUN	NT	
Please complete the information below to ma	ke your ongoing payments e	lectronically through a savi	ngs account.
Name on account: First name	Middle initial	Last name	
Bank name:		Amount \$:	
Bank routing #:	Bank account #:		State:
YOUR NAME 1234 Main Street Anywhere, OH 000000 PAY 10 THE ORDER OF DOLLA ROUTING ACCOUNT CHECK NUMBER NUMBER NUMBER	number.	the image to locate the bar Do not include the check n or account number	
Please use the banking information above to	pay for:		
☐ Ongoing automatic premium payment only	Note: Be sure to sel	ect an option for your first i	month premium payment.
I understand by signing this form, I am giving bank account as indicated above. If you are in			raw payment(s) from my
Signature of bank account holder	Signature of bank ac	count holder (if joint accou	ınt)
X	X		
OPTION 3: CREDIT OR DEBIT CARD PA	YMENT		
Please complete the information below to ma	ke your payment(s) by a cred	lit or debit card.	
Name on account: First name	Middle initial	Last name	
Card type: Uisa Masterca	rd	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 prem	ium payments*	Ongoing automatic premi	um payments only*
I understand by signing this form, I am giving I If you are not the health plan subscriber, che		my credit card as indicated	l above.
Signature of cardholder			
X			

continues on next page... Page 2 of 3

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

Name:	ID:	MEDICA:
OPTION 4: CHECK OR MONI		
Please complete the information	below to make your payment(s) with a check or me	oney order.
Please use the check or money or	rder below to pay for:	
☐ First month premium paymen	nt (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	y order payable to Medica. If you are not the hea	alth plan subscriber, check here $\;\Box\;$
Note: Only include a check or mo	ney order with this form if you're paying for your f	irst month's premium payment.
	Attach check(s) here	
		i

*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 withdraws 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.

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Page 3 of 3