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

MEDICA®

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.

Return completed form to:
Medica CW199IFB
PO Box 9310
Minneapolis, MN 55440-9310

Or, fax it to: 952-992-2851

SUBSCRIPTION INFORMATION

Name:	Date of birth:
Subscription ID (if known):	Group/Policy: IFB

Phone number:

Address 1:

Address 2:

City:

State: ZIP: —

Email address:

Note: Your email address will be used to confirm your enrollment in automatic payments and to communicate the amount and date of when Medica will withdraw your next payment.

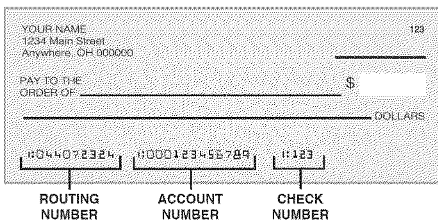
OPTION 1: ELECTRONIC PAYMENT FROM A CHECKING ACCOUNT

Complete the information below to make your payment(s) electronically through a checking account.

Name on account: First name Middle initial Last name

Bank name: Amount $:

Bank routing #: Bank account #: State:



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

Please use the banking information above to pay for:

- ❑ First month premium payment only
- ❑ First month and ongoing automatic premium payments*
- ❑ Ongoing automatic premium payments only*

I understand by signing this form, I am giving Medica and the bank named above permission to withdraw payment(s) from my bank account as indicated above. If you are not the health plan subscriber, check here ❑

Signature of bank account holder
X

Signature of bank account holder (if joint account)
X

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

continues on next page...

Name: ID:

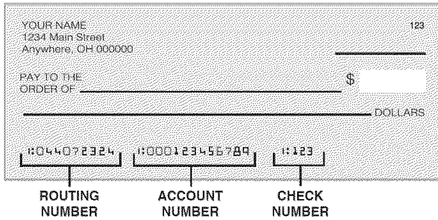
OPTION 2: ELECTRONIC PAYMENT FROM A SAVINGS ACCOUNT

Please complete the information below to make your ongoing payments electronically through a savings account.

Name on account: First name Middle initial Last name

Bank name: Amount $:

Bank routing #: Bank account #: State:



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

Please use the banking information above to pay for:

❑ Ongoing automatic premium payment only* Note: Be sure to select an option for your first month premium payment.

I understand by signing this form, I am giving Medica and the bank named above permission to withdraw payment(s) from my bank account as indicated above. If you are not the health plan subscriber, check here ❑

Signature of bank account holder Signature of bank account holder (if joint account)

X X

OPTION 3: CREDIT OR DEBIT CARD PAYMENT

Please complete the information below to make your payment(s) by a credit 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 payments* ❑ Ongoing automatic premium payments only*

I understand by signing this form, I am giving Medica permission to charge my credit card as indicated above.
If you are not the health plan subscriber, check here ❑

Signature of cardholder

X

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

MEDICA

Name:	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 check or money order below to pay for:

❑ First 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 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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