IMPORTANT: If you have mailed this form within the last 30 days, please disregard unless changing the status.

Authorization Agreement for Automatic Bank Withdrawal (DT-R 321)

For Your Monthly Premium Payment

Avera Health Plans

1. Complete, sign and date the authorization agreement form below.
2. Check one of the following to start, update or stop your automatic bank withdrawal information.
   - ☐ Start (add) Authorization
   - ☐ Update Authorization
   - ☐ Stop (cancel) Authorization
3. Identify the date you are requesting to implement: _____ (MM/YY)

You may cancel your automatic bank withdrawals at any time. We must receive your written notification at least 20 days before your next scheduled bank withdrawal.

POLICYHOLDER INFORMATION

4. Identify type of insurance plan.
   Check One: ☐ Individual ☐ Medicare Supplement ☐ COBRA ☐ Employer Group
5. Policyholder name: _____
6. Or employer group plan name: _____
7. Policy or member number: _____ (found on your member ID card)
   Or Social Security Number: _____ (new members)
8. Email Address: _____

BANKING INFORMATION

9. Check one: ☐ Checking account or ☐ Savings account
10. Bank name: _____
11. Bank resides in city: _____ State: _____
12. Name on bank account: _____
13. Bank account number: _____
14. Nine-digit routing number: _____
    NOTE: Your routing number is located on your check, if not available, please contact your bank.

AUTHORIZED SIGNATURE OF BANK ACCOUNT HOLDER

As the bank account holder, I authorize Avera Health Plans and the financial institution named above to initiate Automated Clearing House (ACH) debit entries from my checking or savings account for my recurring scheduled premium payments, and if necessary, credit entries due to overpayments, refunds, and/or adjustments for any errors to the above designated bank account. This authorization will remain in effect until I have notified Avera Health Plans in writing requesting termination of automatic payments in such time and in such manner as to afford Avera Health Plans and my financial institution a reasonable opportunity to act on it. I agree to notify Avera Health Plans of any changes to the banking information that I have provided. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of the U.S. law. I understand that automatic debits will cease if my coverage ends, or my automatic debit rejects for insufficient funds, in which case, I authorize Avera Health Plans to make a one-time electronic debit entry from my account to collect a bank return fee of $25.

_____ _____

Signature of authorized bank account holder Date

FINAL STEPS: Mail or fax completed form and enclose a voided check or copy of a check.

Mail to Avera Health Plans Finance Dept.
5300 S. Broadband Ln.
Or fax to 605-504-9305
Sioux Falls, SD 57108-2221

Important

Please enclose a voided check or copy of a check.

If questions, please call our Service Center toll-free 1-888-322-2115, 8 a.m. to 5 p.m. CT, Monday through Friday