



Authorization for Automatic Withdrawal of Insurance Premiums

Employer Name:			
Participant Information			
Name (Last, First)		Social Security Number	
Address		City/State/Zip	
Email Address		Phone Number	
<input type="checkbox"/> I hereby authorize OptumHealth Financial Services, Inc. to electronically withdraws the amount of my monthly insurance premium payments from the designated checking or savings account listed below. I also authorize the financial institution indicated to debit such account. <input type="checkbox"/> I understand withdrawals will be made on the 1st of the month for which the payment is due (or on the next banking day if the 1st is a non-banking day). I further understand that this form may take up to 10 business days from the date received to process. If I am mailing this form close to the 1st of the month for which the premium payment is due, I will include a check for the premium payment due on the 1st. Automatic withdrawals will then commence on the following premium payment due date. <input type="checkbox"/> I understand that if my automatic withdrawal is rejected by my bank due to insufficient funds or other circumstances, OptumHealth Financial Services, Inc. may, but is not required to, attempt to resubmit the automatic withdrawal. Any automatic withdrawal not honored by my bank will be considered not paid and could result in cancellation of the corresponding insurance coverage(s). Additionally, the Automatic Withdrawal of Insurance Premiums will automatically be discontinued. Future premium payments must be made via personal check or money order.			
Name of Financial Institution			
Mailing Address		City	State Zip Code
		Routing Number:	
		Account Number:	
		Type of Account <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
		Requested Effective Date:	
		Are there other accounts you wish to have this automatic withdrawal applied to? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		If yes, then please list the other account (i.e. Retiree medical and COBRA dental) or beneficiaries name and social security number (i.e. overage dependent or spouse):	
I understand automatic withdrawals will continue as the premiums come due until I either cancel this agreement by submitting the request in writing or cancel my insurance coverage(s). I agree submission of this agreement does not remove my responsibility to make timely payments for my insurance premiums, which continues to be my sole responsibility.			
Signature:			Date:

* Please attach a voided check and mail completed form to:

OptumHealth Financial Services, Inc.
P.O. Box 740221
Atlanta, GA 30374

** Please **do not send** live payments, check or money order to this address.