UnitedHealthcare
A UnitedHealth Group Company

AUTOMATIC WITHDRAWAL OF INSURANCE PREMIUMS

If you are a participant you can conveniently have your premium payments automatically deducted from your checking or savings account. Simply complete this form and return it to UHCServices. Allow *up to 10 business days* from the date received for processing of this form.

If you have outstanding premium payments due, you may include a check made payable to UHCServices in the amount of the outstanding premium payments along with this form.

☐ **I hereby authorize** UHCServices to electronically withdraw the amount of my Billing insurance premium payments from the designated checking or savings account listed below. I also authorize the financial institution indicated to debit such account.

☐ 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.

☐ **I understand** that if my automatic withdrawal is rejected by my bank due to insufficient funds or other circumstances, UHCServices 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 coverages. Additionally, the Automatic Withdrawal of Insurance Premiums will automatically be discontinued. Future premium payments must be made via personal check or money order.

☐ **I understand** that automatic withdrawals will continue as the premiums come due until such time that I either cancel this agreement by completing a new form or the corresponding coverages expire.

Employer Name: **_PEBC – Parker County_____**

Your Name: _____

Soc. Sec. #: - - _____

E-mail Address: _____

Bank Name: _____

EFT Effective Date: _____

Account Type: **_ Checking _ Savings**

Routing Number: _____

Account Number: _____

Is this request: **_ New _ Change _ Cancel**

Your Signature: _____

Date: _____

PLEASE ATTACH A VOIDED CHECK AND MAIL OR FAX TO:

UnitedHealthcare Benefit Services
P.O. Box 740221
Atlanta, GA 30374-0221

Phone: (877) 237-8576
Fax: (866) 525-1740