HealthPartners

Return completed and signed form to:

Email: premiumbilling@healthpartners.com

Fax: 952-883-9630

Mail: HealthPartners Membership Accounting
PO Box 297
Minneapolis, MN 55440-0297

Automatic Premium Payment Enrollment and Update Form

Use this form to **enroll in or update automatic premium payments** on your HealthPartners Individual policy. When you enroll in auto pay you'll no longer receive a paper invoice. Visit your **healthpartners.com** account to view invoices. **This form cannot be used to enroll or update auto payments on HealthPartners Medicare plans or plans purchased through MNsure and the Federally Facilitated Marketplace.**

ⓘ **Questions?** Contact HealthPartners Membership Accounting at **952-883-5353** or **888-827-0181**, Monday - Friday, 8 a.m. to 5 p.m.

POLICYHOLDER INFORMATION

ⓘ Policyholder information must be completed.

Last name	First name	Middle initial	HealthPartners member number

Date of birth	Preferred telephone number	Alternate telephone number

COVERAGE INFORMATION

ⓘ Provide information on the plan(s) that you would like to enroll or update automatic payments on.

☐ Individual medical plan – **Contract number:**	☐ Individual dental plan – **Contract number:**

Select one: ☐ New automatic payment enrollment ☐ Change existing automatic payment

ⓘ Request received after **the 20th of the current month may not be effective until the following month.** Requests to stop auto pay must be received by the 20th of the current month.

BANK INFORMATION

ⓘ Provide the information for the bank account you would like your premium payments withdrawn from.
Payments will be withdrawn on the first of the month or the first business day of the month.

Select one: ☐ Personal[1] checking account ☐ Personal[1] savings account

Bank account holder's Name	Bank name
9-digit routing number*	Bank account number*

ⓘ *These numbers are at the bottom of your check: ⑆ 123456789 ⑆ 1234567890123 ⑈
Routing Number Account Number

[1]Personal accounts are recommended for automatic withdrawals. Business accounts may have restrictions on electronic deductions which may cause withdrawals to be returned as not paid. Returned payments may lead to additional fees and potential cancelation for non-payment.

CONDITIONS OF ACCEPTANCE

ⓘ Policyholder and account holder (if different from the policyholder) must sign below.

I authorize monthly withdrawals from my bank account to pay monthly insurance premiums for the policyholder named above. **Requests to stop or change ongoing automatic payments must be received by the 20th of the current month.** I understand that fees or rate increases may change the monthly premium, and I authorize the withdrawal of these additional amounts. I agree to pay all charges associated with any payment returned by the bank. If I am not the named policyholder, I understand that I will not have access to or any authority to take action on this insurance policy. I understand that HealthPartners requires authorization from the policyholder to change or discontinue automatic payments. I understand that the policyholder will have access to my bank information and receive any refunds related to this coverage.

Signature of policyholder	Date	Signature of account holder*	Date

ⓘ **Written signatures required, electronic signatures are not accepted.**

**Only required if account holder is different than the policyholder.*

HEALTHPARTNERS USE ONLY

Information below to be completed by HealthPartners Membership Accounting.

Auto pay effective date:	Billing verified:	Bank info verified:	Follow-up complete:	Processed by:	Audited by:

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