Sample voided check

1. Name of financial institution
2. Branch, City, State, Zip
3. ABA routing number
4. Account number

Health Alliance Medical Plans
301 South Vine St. • Urbana, IL 61801

aso-ipxpautoprepay-0810

Automatic Premium Payment Program

- **Timesaving**
- **Worry-free**
- **Convenient**
- **Dependable**

Health Alliance

IPXP

Automatic Premium Payment Program

Enjoy the security of knowing your monthly plan premium is on time with our Automatic Premium Payment Program. It's an easy, dependable way to make your plan premium payments.

IPXP participants:

Your plan premium will be deducted from your bank account the 1st business day of each month. If you have any questions, please call IPXP at1-877-210-9167 or TTY 1-866-883-8551. Representatives are available from 8 a.m. to 5 p.m., Monday through Friday.

All members:

To sign up for our Automatic Premium Payment Program, please complete the attached form and return it in the envelope provided.

If the amount of your plan premium changes, we will inform you at least 30 days in advance.

Automatic Premium Payment Authorization (please print)

Name (First, Middle Initial, Last)

Social Security Number ___ ___ ___

Phone Number ( )

Make this deduction from:

☐ Checking (Enclose voided check) ☐ Savings

See sample on back for information below.

Financial Institution of Payor

Name

Branch

City State Zip

ABA#

Account#

I hereby authorize Health Alliance Medical Plans, Inc., and the financial institution named above to initiate monthly debit entries, on the appropriate date and in the amount of the current premium for my plan, and to initiate, if necessary, credit entries and adjustments for any debit entries in error to the account and financial institution indicated above. This authority is to remain in effect until Health Alliance has received written notification from me at least 15 days prior to the date of its termination.

Signature Date