



## Change Method of Premium Payment

Requests to change the method of your monthly premium payments may be made at renewal. To request a change, please indicate which billing method you are changing to and complete all applicable information. You will then need to sign, date and return this form to CoventryOne. See the bottom of this form for details.

**If you are happy with the way your monthly premium payments are currently being paid, you do not need to take any action.**

### Monthly Bank Draft

Member ID: \_\_\_\_\_

Please note that premiums will be paid from funds withdrawn on the 10<sup>th</sup> day of each month (or next business day).

**A voided check or savings account deposit slip should be attached in support of content in this section**

**Please provide the following information:**       Checking Account     Savings Account

Name of Bank or Savings Institution: \_\_\_\_\_

9-Digit Routing Number: |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

Account Number: \_\_\_\_\_

Name that appears on the Account: \_\_\_\_\_ Address on the Account: \_\_\_\_\_

NAME	0123
ADDRESS	01-23456789
CITY, STATE, ZIP	DATE _____
PAY TO THE ORDER OF	\$ _____
DOLLARS	
BANK NAME	
ADDRESS	
CITY, STATE, ZIP	
FOR	
⑆0123456789⑆	⑆01234567890123⑆
⑆0123	

Routing #    Account #

If premium payment is returned unpaid a Return Check Fee amount will be assessed in the amount of \$20.00. Account Holder hereby authorizes CoventryOne to collect the premium payment due on the 20<sup>th</sup> of the month, or next business day, including the Return Check Fee amount, via electronic funds transfer (EFT) or automatic withdrawal from the account identified and provided herein or then current.

By signing below, I authorize Coventry Health Care of Georgia, Inc. to initiate automatic withdrawal of applicable premium payments from the account listed above.

**I understand that it is my responsibility to notify the Plan if I change banks or account numbers.**

Account Holder Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Account Holder Name (print): \_\_\_\_\_

Date: \_\_\_\_\_

Please Print

### Monthly Billing

Member ID: \_\_\_\_\_

Please note that premiums are due on the 1st day of each month. **A \$5.00 administrative fee will be added to each month's premium for monthly billing.**

Setup for monthly billing may take up to 45 days. Once your request is submitted, you may incur another bank draft prior to receiving the first monthly billing statement.

Member's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Account Holder Name (print): \_\_\_\_\_

Date: \_\_\_\_\_

**Complete, sign, date and fax this form to CoventryOne at 1-866-635-9392**

**or mail the completed form to CoventryOne, Attn: A/R ACH, PO Box 2778, Bismarck ND 58502.**