Automatic Premium Payment Authorization for Payment of Health Premiums

I hereby authorize Health Alliance™ and the financial institution named below 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 below. This authority is to remain in effect until Health Alliance has received written notification from me of its termination in such time as to afford Health Alliance and the financial institution a reasonable opportunity to act on it.

_____ _____

(Group Name) **(Group Number)**

_____

(Account Holder Name – must be exactly as it appears on checks)

_____ _____

(Bank ABA Routing Number) **(Account Number)**

_____

(Street Address – as it appears on checks)

_____

(City, State and ZIP Code – as it appears on checks)

Authorized Signature: _____

Date: _____

Mail to:

Health Alliance Medical Plans
3310 Fields South Dr.
Champaign, IL 61822

Fax #: (217) 902-9784
Email to: Receivables@HealthAlliance.org

GPMKHA23-recurcheck-1022