

# Transition Plan Payment Selection Form

Applicant's Name \_\_\_\_\_ Applicant's Social Security# OR Subscriber ID# \_\_\_\_\_  
(internal use only)

## A. PAYMENT SELECTION

Please select one of the two available methods of payment for your monthly premium. **Your employer cannot** pay any portion of your premium, either directly or through reimbursement. Submit only personal account information.

**Single Payment - Complete section B below.**

You select both the start and end date of coverage and pay for the entire plan term in advance.

**Monthly Payment - Complete section C below.**

You select a start date and pay your first month's premium in advance. SelectHealth will automatically withdraw premium each month until: a) you notify SelectHealth in writing you wish to terminate your coverage, or b) you reach the maximum six months of coverage.

## B. SINGLE PAYMENT OPTION

You may pay your full premium using a credit/debit card or with an electronic check.

### Credit/Debit Card

Select Card Type

- Visa       MasterCard®  
 Discover®     American Express®

Card# \_\_\_\_\_

Expiration Date \_\_\_\_\_

Name on Card \_\_\_\_\_

Billing ZIP \_\_\_\_\_

### Electronic Check

Account Holder's Name \_\_\_\_\_

Account Holder's ZIP \_\_\_\_\_

Account# \_\_\_\_\_

Financial Institution \_\_\_\_\_

Routing & Transit# \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_ Account Holder's Signature \_\_\_\_\_

## C. MONTHLY PAYMENT OPTION

If you select this method of payment for your monthly premium, your payment will automatically be deducted from your checking/savings account each month. Please complete the information below.

I (we) authorize SelectHealth to initiate debit entries to my (our)  **Checking Account**  **Savings Account**

Account Holder's Name \_\_\_\_\_ Account# \_\_\_\_\_

Financial Institution \_\_\_\_\_ Routing & Transit# \_\_\_\_\_

I (we) understand that debit entries will be submitted to my (our) account on or about the tenth of each month, regardless of the policy effective date. I (we) understand that a **\$25.00 service charge** will be assessed if the premium amount cannot be deducted from my (our) account for any reason.

Account Holder's Signature \_\_\_\_\_

## MONTHLY PAYMENT

### Attach a Voided Check Here

Do not use a checking deposit slip for checking withdrawal.  
Checking deposit slips do not always contain the necessary routing and transit information.

Check#                      Routing & Transit#                      Account#  
00 1099                      1 2400494 1                      18 3940 19 23