

# PAYMENT OPTIONS CHANGE FORM

## Personal Information

**Member Name (print):** \_\_\_\_\_

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

I hereby authorize Soundpath Health (HMO), its affiliates and subsidiaries, to deduct my insurance premium payments as indicated below:

## Payment Options

**To change how you pay your plan premium, please select ONE of the following payment options:**

- Electronic Funds Transfer (EFT) from my bank account on the 3rd business day of each month.

Please enclose a VOIDED check and provide the following:

Account holder name: \_\_\_\_\_

Bank routing number:

Checking

Savings

Bank account number:

- Receive a monthly billing statement.
- Automatic deduction from my monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. If Social Security or RRB payment is delayed, or they do not approve your request for automatic deduction, we will send you a paper bill for any monthly premiums owed.)

If you qualify for extra help with your Medicare Prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you do not select a payment option, you will receive a monthly billing statement if applicable.

\_\_\_\_\_  
**Print member name**

\_\_\_\_\_  
**Signature of Medicare beneficiary  
or bank holder**

\_\_\_\_\_  
**Date**