UnitedHealthcare
A UnitedHealth Group Company

Authorization for Automatic Withdrawal of Insurance Premiums

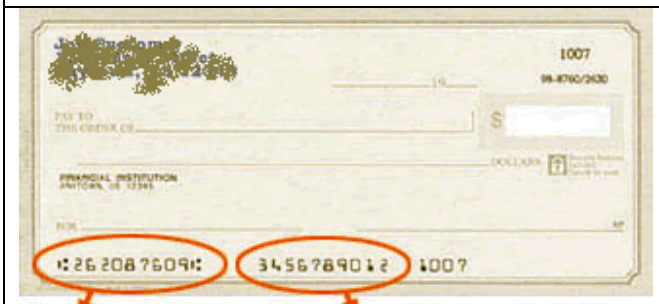
Employer Name	
Participant Information	
Name (Last, First)	Social Security Number
Address	City/State/Zip
Email Address	Phone Number

☐ **I hereby authorize** UnitedHealthcare to electronically withdraw the amount of my monthly insurance premium payments from the designated checking or savings account listed below. I also authorize the financial institution indicated to debit such account.

☐ **I understand** withdrawals will be made on the 1st of the month for which the payment is due (or on the next banking day if the 1st is a non-banking day). I further understand that this form may take up to 10 business days from the date received to process. If I am mailing this form close to the 1st of the month for which the premium payment is due, I will include a check for the premium payment due on the 1st. Automatic withdrawals will then commence on the following premium payment due date.

☐ **I understand** that if my automatic withdrawal is rejected by my bank due to insufficient funds or other circumstances, UnitedHealthcare may, but is not required to, attempt to resubmit the automatic withdrawal. Any automatic withdrawal not honored by my bank will be considered not paid and could result in cancellation of the corresponding insurance coverage(s). Additionally, the Automatic Withdrawal of Insurance Premiums will automatically be discontinued. Future premium payments must be made via personal check or money order.

Name of Financial Institution			
Mailing Address	City	State	Zip Code



Routing Number

Account Number

Type of Account ☐ Checking ☐ Savings

Requested Effective Date

I understand automatic withdrawals will continue as the premiums come due until I either cancel this agreement by submitting the request in writing or cancel my insurance coverage(s). I agree submission of this agreement does not remove my responsibility to make timely payments for my insurance premiums which continues to be my sole responsibility.

Signature:	Date:

** Please attach a voided check and mail or fax signed form to:

UnitedHealthcare
P.O. Box 1747
Brookfield, WI 53008-1747

Phone: (866) 747-0048
Fax: (262) 879-0719
Business Hours: 7:00 am to 7:00 pm Central Time