

Never miss a payment. Automatic payment provides you peace of mind. **Sign up today.**

SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000
1-800-472-2363
715-221-9555
TTY 711
Fax: 715-221-9500

www.securityhealth.org

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Limited English proficiency language services
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY 711).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY 711).
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY 711).

If you require materials in large print, please call 1-800-472-2363 (TTY 711).

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HP-30528 (04/22) 30169-000

Employer Automatic Premium Payment Plan

- Time-Saving
- Worry-Free
- Convenient
- Dependable

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Employer Automatic Premium Payment Plan

For your convenience, you may have your monthly premium payments made automatically from your checking or savings account. This automatic payment plan provides an easy, dependable way to make premium payments.

To sign up, please complete the form (at right), detach and return it with your billing statement or employer group application.

Mail to:
Attention - ACH Department
Security Health Plan
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

or email to:
shp.acct.receivable@securityhealth.org

- Please allow up to 60 days for your authorization form to be processed and your first automatic payment to be deducted.
- We will notify you on your bill when you can expect your payments to begin.
- Your premium will be deducted on the 20th of the month preceding the month of coverage. If the 20th falls on a weekend or holiday, the deduction will take place on the following business day.
- Changes not received five business days prior to the end of the month will not be reflected until your next bill.

If you have any questions or are interested in setting up an automatic payment, please contact your Account Manager.

Employer Automatic Premium Payment Authorization

Employer name

Employer address

Phone number ( ) – –

Make this deduction from:

☐ **Checking** (enclose your voided check if sent by mail)

☐ **Savings** (indicate account no.)

Savings account number

Financial Institution of Payor

See check sample below when completing 1 to 3 below.

1 Financial Institution Name

FEIN

2 ABA routing number

3 Account number

I (Payor) authorize Security Health Plan of Wisconsin, Inc., and the financial institution named above to initiate entries to my checking/savings account for payment of premiums. This authority will remain in effect until I notify you (Plan) and the financial institution in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I understand that the premium will be deducted on or after the 20th of the month. I can stop payment of any entry by notifying you and my financial institution 7 days before my account is charged.

Authorized signature | Date (m/d/y)

Additional signature (if required) | Date (m/d/y)

Check sample

