SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

(844) 293-9624 or (715) 221-9258
TTY: 711 | Fax: (715) 221-9500

Individual and Family Plan

Automatic Premium Payment Plan

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

- 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 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 amount of your premium changes you will be informed in advance.
- If you have any questions please call our Customer Service Department at (844) 293-9624 or (715) 221-9258, between 7 a.m. and 5:30 p.m., Monday through Friday. If you are hearing or speech impaired, call TTY: 711.

You can sign up for an automatic premium payment plan through your *My Security Health Plan* online account or complete one of the forms below, detach and return it with your billing statement or new application packet, email to shp.acct.receivable@securityhealth.org, or mail to:

Attn: ACH Department, Security Health Plan, P.O. Box 8000, Marshfield, WI 54449-8000

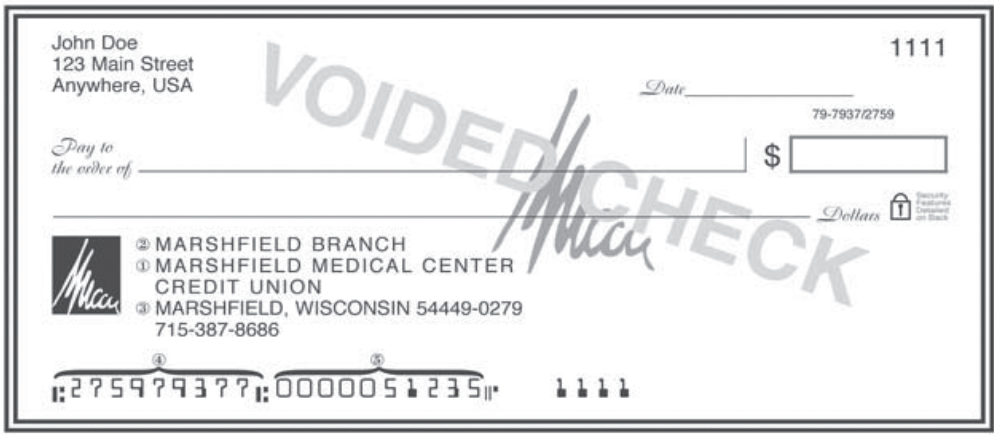
Automatic premium payment authorization

Subscriber name (last, first, middle initial)	Financial institution of payor *(see sample below when completing 1 – 5 below)*	
Mailing address	1 Name	
Phone number ( )	2 Branch	
Make this deduction from: ☐ **Checking** (enclose voided check) ☐ **Savings** (indicate account no. here) _____	3 Address	
	4 ABA routing number	5 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 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. I understand the amount of an erroneous charge will be credited to my account upon notification.

_____ ____ /____ /____ _____ ____ /____ /____

Payor signature | Date (m/d/y) | Subscriber signature (if not payor) | Date (m/d/y)



Credit/debit card payment method *(We accept Visa, MasterCard and Discover.)*

Name on card		
Card number		
Card security code (3-digit code on back of card)	Expiration date (mm/yy)	
Billing address		
City	State	ZIP code

I hereby authorized Security Health Plan of Wisconsin, Inc., and Chase Paymentech Services to initiate a debit to my credit or debit card for payment of premiums. I understand that this authorization is to remain in effect unless I notify Security Health Plan and the financial institution of a change within a time and manner as to afford Security Health Plan and the financial institution a reasonable opportunity to act on it.

_____ ____ /____ /____

Payor signature Date (m/d/y)

Notice of nondiscrimination

Security Health Plan of Wisconsin, Inc., complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Language assistance services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call (844) 293-9624 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (844) 293-9624 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (844) 293-9624 (TTY: 711).

If you require materials in large print, please call (844) 293-9624 (TTY: 711).

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