

**BANK ACCOUNT DEBIT FORM**

*This form authorizes the Health Plan to collect your health premium directly from your bank or financial institution on an ongoing basis. Please mail this form to the Health Plan office or fax to (323) 866-2399.*

Payment will be processed on the first non-holiday weekday (Mon-Fri) of the month in which it is due. If your bank account information changes, you must notify the Health Plan of the new information prior to the end of the month in which your premium is due. Otherwise, we will be unable to process your payment prior to the end of your grace period.

**CHECK ONE:** **DEPENDENT PREMIUM** **SELF-PAY PREMIUM**

Participant Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Daytime Phone Number: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Bank Account Routing Number: \_\_\_\_\_

Please write the premium amount below, as well as the dates on which the Health Plan should begin and end the collecting of your health care premium directly from your bank or financial institution.

Premium Amount: \_\_\_\_\_ First Charge Date: \_\_\_\_\_ Last Charge Date: \_\_\_\_\_

I hereby authorize the Directors Guild of America-Producer Health Plan to debit my account electronically for the amount of my Health Plan premium. I understand that this is a recurring transaction and that it will debit (charge) my account. Along with this completed, signed form, I have included:

- A copy of a voided check (which gives the Health Plan all of the necessary information to set up my recurring payment); and
- A check for my next premium payment (the Health Plan requires 30 days processing time to institute the bank debit payment process). Past due payments cannot be made through bank debit.

I understand that if, at any time, my account does not accept the charge, I and/or my dependents are responsible for the premiums due to the Health Plan or my coverage will be canceled. I understand that this election is revocable by me at any time and that the Directors Guild of America-Producer Health Plan reserves the right to cancel this agreement at any time by notifying me in writing.

Participant Signature:  X  \_\_\_\_\_ Date: \_\_\_\_\_