

PREMIUM PAYMENT FORM

If you would like to pay your premium via credit card or bank account debit, please return this form to the Health Plan office by mail to **DGA-Producer Health Plan, 8436 W. 3rd Street, Ste. 900, Los Angeles, CA 90048-4180** or fax it to **(323) 866-2399**. Please note that the dependent premium can be paid in six-month increments, but not for a shorter period.

Participant Name: _____

SSN or Health Plan ID Number: _____

Daytime Phone Number: _____

Paying by Credit Card
Type of Premium: <input type="checkbox"/> Dependent Premium <input type="checkbox"/> Self-Pay Premium
Amount to Charge:
Charge Type: <input type="checkbox"/> One-Time <input type="checkbox"/> Recurring
Charge Frequency: <input type="checkbox"/> Monthly (self-pay premiums only) <input type="checkbox"/> Quarterly (self-pay premiums only) <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually
Card Type (mark one): <input type="checkbox"/> American Express <input type="checkbox"/> Discover Card <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa
Name of Cardholder:
Card Number:
Expiration Date:
CVV Code (3- or 4-digit number on back of card):

Paying by Bank Account Debit
Type of Premium: <input type="checkbox"/> Dependent Premium <input type="checkbox"/> Self-Pay Premium
Amount to Charge:
Debit Type: <input type="checkbox"/> One-Time <input type="checkbox"/> Recurring
Debit Frequency: <input type="checkbox"/> Monthly (self-pay premiums only) <input type="checkbox"/> Quarterly (self-pay premiums only) <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually
<i>In lieu of providing the information below, you can send a copy of a voided check to the Health Plan along with this form.</i>
Bank Name:
Account Number:
Routing Number:

I hereby authorize the DGA-Producer Health Plan to charge my credit card or debit my bank account for the amount indicated above. If I have elected a recurring transaction, I understand that it will be automatically debited/charged while I and/or my dependents are covered under my Health Plan coverage based on the frequency indicated above. I understand that if my bank/credit card company does not accept the debit/charge, the coverage will be canceled if an alternate form of payment is not made to the Health Plan prior to the expiration of the grace period. I understand that this election is revocable by me at any time and that the Health Plan reserves the right to cancel this agreement at any time by notifying me in writing.

Cardholder Signature: X _____

Date: _____