SAG-AFTRA HEALTH PLAN

3601 W. Olive Ave., Burbank, CA 91505 • Mailing Address: P.O. Box 7830, Burbank, CA 91510-7830
P (800) 777-4013 • F (818) 953-9880 • www.sagaftraplans.org/health

Automatic Premium Payment Form

Enjoy the security of knowing that your premium is paid on time by using our automatic payment option. When you sign up, your premium will be deducted on a recurring basis from a U.S. checking or savings account. If you are on the COBRA program — or have 'senior performers' or 'surviving dependent' coverage — your payments will be deducted monthly on the 25th of the month prior to the due date. If you have 'earned' coverage, your premiums will be deducted quarterly on the 25th of the month prior to the due date.

To get started, register using your Benefits Manager at www.sagaftraplans.org/health and click on "sign up for automatic payments." You can also complete and sign the form on the back; please mail or fax the completed form to the Plan, and be sure to include all of the required bank information. Key points to consider:

- If you are currently covered and are enrolled in automatic payments, you do not need to submit this form or a payment at this time. Your payment will continue to be deducted automatically.
- Completed applications must be received in our office 15 days prior to the premium due date. Enrollment in automatic payments may be delayed if your premiums are not current.
- As long as you are eligible for coverage the Plan will automatically deduct your premiums. This will occur regardless of changes in the premium rate or benefit plan (e.g., going from Plan I to Plan II).
- You will need to complete a new automatic payment application if your coverage is interrupted, or changes from COBRA to 'earned' or from 'earned' to COBRA.
- Advance notification will be sent in the event of any change in your eligibility status or premium rate. You will be charged a fee of $25.00 for a declined automatic payment transaction.
- Cancellation or change in bank account information requires a written request and must be received in our office 15 days prior to the premium due date. We cannot process verbal requests.

If you have questions, call us at (800) 777-4013 or log in to your Benefits Manager at www.sagaftraplans.org/health and use the message center. You can also view your earnings, pay premiums, sign up for Plan emails and more.

Automatic Premium Payment Application

☐ New Applicant ☐ Change *(change in bank or account information)*

Print name of participant or surviving dependent: _____

Participant SSN/HCID: _____ Automatic payment effective date: _____

Mark one box only: ☐ Checking account (attach voided check below) ☐ Savings account

Name of bank: _____

Bank address: _____

Bank account number: _____

Routing number: _____

I, _____
(participant or account holder if not participant)

authorize the SAG-AFTRA Health Plan (Plan) to withdraw the scheduled monthly and or quarterly (whichever is applicable) Plan premium payment from my checking or savings account on approximately the 25th of the month prior to the due date based on the information provided by me on this form. **I further authorize the Plan to adjust this withdrawal to reflect any rate change that may occur.** The Plan's authority is to remain in full effect until the Plan has received written notification from me of its termination or until the Plan has sent me a 10-day written notice of the termination of this agreement.

_____ _____
Participant/surviving dependent signature (required) Date

_____ _____
Account holder signature (required if not participant or surviving dependent) Date

Automatic payment applies to U.S. bank accounts only.

ATTACH VOIDED CHECK