WPS HEALTH INSURANCE

Arise HEALTH PLAN

PAYMENT AUTHORIZATION FORM

ACCOUNT HOLDER INFORMATION:

Name _____

Subscriber Number (if available)_____Social Security Number _____-_____-_____

Mailing Address:

City _____ State_____ ZIP_____County_____

AUTOMATIC WITHDRAWAL

Select One: ❑ Checking Account ❑ Savings Account

Routing Number _____ Account Number _____

Bank Name _____

By my signature below, I authorize the Insurer to instruct my financial institution to deduct my premium payments from the account designated above. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify the Insurer in writing of its termination. My notification must afford the Insurer and my financial institution reasonable opportunity to act on it.

PAYMENT WITHDRAWAL DATE:

Recurring Payment: Please select one of the following:

☐ 1st day of the month

☐ 20th of the month prior

Note: Recurring premium payments will be charged to your checking/savings account based on your selection above. We will continue to charge premiums until the policyholder notifies us to discontinue charging premiums in accordance with the Insurer's policy. If you do not choose a day, the payment pull will occur on the 20th of the month **prior** to the payment due date.

MAIL PAYMENT TO:

WPS Health Insurance
P. O. Box 9
Madison, WI 53701-0009

OR

Arise Health Plan
P. O. 8160
Madison, WI 53708-8160

SIGN HERE ⇨ _____ _____

Applicant's Signature *Date*

SIGN HERE ⇨ _____ _____

Account Holder (if different from Applicant) *Date*

PLEASE E-MAIL THIS SIGNED AND COMPLETED FORM TO: **billing@wpsic.com**
OR FAX THIS SIGNED AND COMPLETED FORM TO **608-223-3639.**

29551-051-1801

FINANCIAL INFORMATION