Section X. Premium Payment Information

For your coverage to become effective, you must submit the first month's premium with your application and make arrangements for future premium payments. If you are NOT approved, your check will be returned to you.

Initial Premium Payment: Please submit one month's premium for your chosen health plan.

In which region do you live? ☐ North ☐ South ☐ East ☐ Central What is your age? ______________________________

Which type of coverage did you choose? ☐ Single ☐ Family What plan did you choose (Plan A, B or C)? _______________

Using the above information, refer to the premium chart in your enrollment kit to determine what the month's payment would be if accepted into the plan. **Make your check or money order payable to AccessWV.** If you are denied coverage, this check or money order will be returned to you.

Attach First Month's Payment Here

Going forward, I would like to pay my premium by the following method (check one):

☐ Billed to me on a monthly basis.

☐ Automatic payment deducted directly from my bank account on a monthly basis
(If checked, complete authorization agreement below).

AUTHORIZATION AGREEMENT FOR MONTHLY AUTOMATIC BANK PAYMENT

Name of Applicant or Policyholder: ____

Social Security Number: ____

I (or we if a joint account) authorize AccessWV to charge my (our) checking account for monthly insurance premiums. I (we) authorize the financial institution named below to honor and pay these monthly charges. This authority is to remain in effect until revoked by me (us) in writing, and until you actually receive such notice, I (we) agree that you shall be fully protected in honoring any such check/draft. I (we) understand that in order to cancel these automatic deductions, I (we) must provide written notice to AccessWV no less than 15 days before the next scheduled automatic deduction.

YOU MUST ATTACH A VOIDED CHECK WITH THIS AUTHORIZATION AGREEMENT TO BE USED BY THE BANK TO SET UP THE AUTOMATIC PAYMENT

Authorization Signature: ____

Account Number: ____

Financial Institution: ____

Note: If this form is not completed and signed, premiums will be billed on a monthly direct bill basis. You must pay the billed premium until your bank processes this authorization or your coverage will be affected.

Attach Voided Check Here for Automatic Payment