Authorization for Automatic Transfer of Funds (Form B)

WellFirst Health Insurance offers an easy way to make monthly premium payments, called the **Direct Premium Payment Program**. This service allows WellFirst to automatically transfer funds from your checking or savings account on a monthly basis to pay your monthly premiums. This program ensures your monthly premiums will be paid timely even if you are traveling and there is no cost to you for this service.

To participate, simply sign this authorization and attach a voided check that shows the bank and account number. Please be sure to fill in your financial institution name, routing number and account number below. We will take care of the rest!

The Direct Premium Payment Program will generally start on the 23rd of the month following acceptance of your application. You will receive a letter prior to the first transfer notifying you of the amount that will be transferred from your account and when the first transfer will occur. Thereafter, your monthly premium will be transferred from your account on the 23rd of each month or the business day following. Any transactions that are not possible due to insufficient funds will be your responsibility.

If you have any questions, please contact the Customer Care Center at (866) 514-4194, TTY users dial 711, Monday through Thursday 7:30 a.m. to 5:00 p.m. and Friday 8:00 a.m. to 4:30 p.m. Form B can be submitted along with your application or mailed direct to WellFirst Health Insurance Enrollment Department, 1277 Deming Way, Madison, WI 53717.

By the Authorized Bank Account Holder signature below, I authorize SSM Health Insurance Company, as the insurer offering WellFirst, to instruct my financial institution to deduct my premium payments from the account designated below. I authorize the financial institution to debit the amount of my premium from my designated account. This authorization is to remain in full force and in effect until WellFirst has received written notification from the individual member of their termination in such time and in such manner as to afford WellFirst and the financial institution a reasonable opportunity to act on it.

Name of Account Holder (please print) _____

Name of Financial Institution _____

Routing number | | | | | | | | | | Type ☐ Checking ☐ Savings

Account number | | | | | | | | | | | | | | | | | |

Signature of Authorized Bank Account Holder _____

Date (mm/dd/yyyy) _____

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WellFirst is underwritten by SSM Health Insurance Company