MEDICA®
Individual & Family Health Plans

PREMIUM PAYMENT OPTIONS

Select how you'd like to pay your first month and ongoing premium payments. Then complete the information below it. You also may pay your premium online by visiting **medicamember.com.**

Please PRINT CLEARLY in blue or black ink.

Return completed form to:
Medica
CW297IFB
PO Box 9310
Minneapolis, MN 55440-9310

Or, fax it to: 952-992-2851

APPLICANT INFORMATION

Primary applicant's name	**Date of birth**

$ OPTION 1: ELECTRONIC PAYMENT FROM A CHECKING ACCOUNT

Complete the section below if you'd like to make your payment(s) electronically through a checking account. Please attach a voided check **OR** complete the information below.

Bank name

Name on account (exactly as it appears on the account)
First name Middle initial Last name

Phone number

Address (If different than applicant's mailing address)
Street City State Zip Code

Bank account #

Bank routing #

Amount $

Please use the banking information above to pay for my

❒ First month premium payment only

❒ First month and ongoing automatic premium payments*

❒ Ongoing automatic premium payments only*

I understand by signing this form, I am giving Medica and the bank named above permission to withdraw payment(s) from my bank account as indicated above.

Signature of bank account holder	**Signature of bank account holder** (if joint account)
X	X

***IMPORTANT NOTICE FOR AUTOMATIC MONTHLY PAYMENTS:**
This agreement will remain in effect until I notify Medica and my bank in writing to cancel it. If you wish to stop automatic payments, you must notify Medica seven business days prior to the month your premium is due.

If the necessary funds are not present in my account the designated day for automatic payment, Medica will send me an invoice for the past due premium. This premium must be paid in order to avoid termination of my policy. I understand that I will be liable for any expenses Medica may incur following my termination date if termination results from non-payment.

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$ OPTION 2: ELECTRONIC PAYMENT FROM A SAVING ACCOUNT

Complete the section below if you'd like to make your ongoing payments electronically through a savings account. Please attach a deposit slip **OR** complete the information below.

Bank name

Name on account (exactly as it appears on the account)

First name Middle initial Last name

Phone number

Address (If different than applicant's mailing address)

Street City State Zip Code

Bank account #

Bank routing #

Amount $

Please use the banking information above to pay for my

❒ Ongoing automatic premium payments only*

Note: Be sure to select an option for your first month premium payment.

I understand by signing this form, I am giving Medica and the bank named above permission to withdraw payment(s) from my bank account as indicated above.

Signature of bank account holder

X

Signature of bank account holder (if joint account)

X

$ OPTION 3: CREDIT OR DEBIT CARD PAYMENT

Complete the section below if you'd like to make your first month premium payment by a credit or debit card.

Note: Credit or debit card payments are only accepted for the first month premium payment.

Card type

❑ Visa ❑ Mastercard ❑ Discover ❑ American Express

Amount $

Card number — — —

Expiration date /

Security code

Name on account (exactly as it appears on the credit card)

First name Middle initial Last name

Phone number

Address (If different than applicant's mailing address)

Street City State Zip Code

Please use the card information above to pay for my

❒ First month premium payment only

I understand by signing this form, I am giving Medica permission to charge my credit card as indicated above.

Signature of cardholder

X

* Please see ***Important Notice for Automatic Monthly Payments*** on the bottom of page 1.

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$ OPTION 4: CHECK OR MONEY ORDER PAYMENT

Complete the section below if you'd like to make your payment(s) with a check or money order.

I would like to use a check or money order to pay for my

❒ First month premium payment (include check or money order with this form)

❒ Ongoing premium payment (we'll mail you an invoice each month)

Amount $

Please make your check or money order payable to **Medica**.

Note: Only include a check or money order with this form if you're paying for your first months premium payment.

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability, or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Lori Braegelman, Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, lori.braegelman@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的 Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ္ပါအဲဉ်ဒီးတၢ်ကျိးထံစၢးကလီနှၤ်နၤတၢ်ဂ့ၢ်တၢ်ကျိုးဆံးလၢးဒုကလီနှဉ်.ကိးလီတဲစီနှဉ်ဂ့ၢ်လၢးဒပဉ်ယှာ်လၢးလံာ်တီလံာ်မီဒုပူးဆံးမ့တမ့ၢ်ဖဲနနှနီဒဲခေ လံာ်ဆုဉ်သးခးကုဒုလျိၤခံတကပၤးဒဖိခိဉ်နှဉ်တက့ၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ሀ ሰነድ ዉስጥ ያለውን ቁጥር ወይም Medica መታወቅያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoosMedica bee néího'dílzinígí bine'déé' námboo biká'ígííjį' béésh bee hodíilnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.

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