MEDICA®

Scheduled Direct Debit Authorization Form

Here's How You Benefit From Scheduled Direct Debit:

- ***Peace of Mind –*** have peace of mind that your Medica coverage continues because your health plan premium is paid on time, every time.
- ***Easy –*** no more wondering if you have envelopes, stamps or checks on hand.
- ***Safe –*** Automatic premium payment is a safe transaction, protecting you and your hard-earned money. Scheduled Direct Debit is a fund transfer system with national rules, standards and procedures that allows financial institutions to make electronic payments on behalf of its customers.

Enrollment Instructions

1. Complete the form below.
2. List all customer numbers and bill groups that you wish to have paid by automatic withdrawal.
3. Attach a copy of a voided check showing the bank account to debit (Do not send a deposit slip).
4. Mail the form and copy of the voided check to:

   Medica
   MN015-2838
   4316 Rice Lake Road
   Duluth, MN 55811

   Or Fax the form and copy of the voided check to: (218) 279-6466

- Once your Scheduled Direct Debit has been activated your first invoice remittance stub will indicate: "Do not mail/submit payment." A request for fund withdrawal will be initiated from your bank account on the 10th of the month. Please allow one month for activation.
- If you wish to speak to someone in further detail regarding this process, please call us at **1-800-892-8354.**

I hereby authorize Medica, Inc. to initiate monthly debits (payments) from the financial institution indicated below. Medica will use these debits to pay my group's monthly bill. Medica's authorization to debit my account will remain in full force and effect until I notify Medica in writing of its cancellation at least 30 days prior to the draft date. I understand all terms and conditions on this form.

_____ Authorized Signature and Title	_____ Date
_____ Employer Name	_____ Customer Number and Bill Group(s)
_____ Name & phone number of Financial Institution	_____ American Bankers Association (ABA) Routing #
_____ Address of Financial Institution	_____ Account Number to Debit

I understand that a draft notice will be sent to me prior to the funds being withdrawn from my account. I understand that if the necessary funds are not available on the day of the draft to cover my premium invoice, my group's coverage may be subject to termination under the terms stated in the contract with Medica. I will also be liable for any expenses incurred by Medica subsequent to the termination date as a result of insufficient funds.