



Automatic Payment ACH

Welcome to Prominence Health Plan!

This form provides authorization to draft your monthly premiums.

Please fill out the information below to have an ACH withdrawal for your initial and monthly payments.

Company Name _____
Billing Address _____
City _____ State _____ Zip/Postal code _____
Email Address _____

Monthly Premium Information

Initial Premium Payment Amount \$ _____

Bank Account Type: ☐ Checking ☐ Savings

Account Holder Name _____
Routing Number _____
Account Number _____

If paying by credit card:

(Please note, Visa and MasterCard payments will incur a processing fee automatically applied to the charge. We do not accept American Express)

Account Holder Name _____
Account Number _____
Security Code _____ (3 to 4 digit code on back of card) EXP Date _____

Authorization Agreement

I understand that by completing this form I am authorizing Prominence Health Plan to withdraw the **INITIAL PREMIUM PAYMENT AND SUBSEQUENT MONTHLY PREMIUMS** from my bank or credit card account. I understand that this payment will be deducted from my account within 1 to 2 business days after notification of group health plan approval and will be recurring monthly within 3 business days after the monthly bill is generated. For notification of credit card changes, please contact our billing department at 775-770-9345 or PHP-PremiumBilling@uhsinc.com

Name (Printed) _____ Title _____

Signature _____ Date Signed _____