Premium Payment Option Change Form

Please use one (1) form for each Member

Please complete the information below to tell us how you would like to pay your monthly premium. After you return this form, it may take up to 3 months for the change to be effective.

This form does not apply to members that are in a $0 premium plan or don't have a late enrollment penalty

Please complete, sign and return this form by mail or fax to:

Email	achinfo@clearspringhealthcare.com
Fax	1-866-643-6159
Mail	PO Box 278470 Miramar, FL 33027 ***Do not send payments to the address above.***

Member ID Number:		
Member Name (first and last):		
Address:		
City:	State:	Zip Code:
Home Phone Number:	Other Phone Number:	

Important Information:

- We do not accept bank information over the phone or credit card payments.
- Members enrolling in an auto deduction premium payment option (SSA, RRB, EFT) will not receive a monthly invoice unless there is an outstanding balance.
- **It may take up to three months for your new payment option to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.** Any outstanding balance prior to effective date of new premium payment option must be paid with a check.

Select a payment option below and return this form before the end of the month.

◯ **Social Security (SSA)/Railroad Retirement Board (RRB).** In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction may include premiums due after you submit this form. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

◯ **Deduction from my Bank Account (ACH)** (please complete the fields listed below). Your payment will be deducted between the 5th and 7th each month. We'll only try to deduct your premiums once each month. If your bank rejects or returns your premiums deduction, we'll send you a letter with instructions on other ways to pay your premiums.

Bank Account Holder Name:	
Bank Name:	Type of Account: ◯ Checking ◯ Savings
Routing Number:	Account Number:

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Please attach a blank, voided check, we'll use it to validate the routing and account numbers you provided on the form. By signing below, you authorize Clear Spring Health to deduct your monthly premium from your bank account.	
Bank Account Holder Signature:	Date:
◯ **Monthly Invoice**. I do not want to enroll OR I want to discontinue the auto deduction payment options listed above. We will mail you a monthly premium statement. Premiums are due on the first day of every month. Please mail payments to: PO Box 74007287 Chicago, IL 60674-7287 Please include your member ID number on the memo section of the check.	
Do you have questions on completing this form? If you have any questions, please call our Member Services department at 1-877-317-6082. TTY users should call 711. We are open from October 1 – March 31, seven days a week, from 8:00am – 8:00pm and from April 1 – September 30, Monday through Friday, 8:00am – 8:00pm (you may leave a voicemail Saturday, Sunday and Federal Holidays).	

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística llame al 1-877-317-6082 (TTY:711).