



Automated Monthly Payment Option (AutoPay)

An automatic payment plan for LifeWise Individual, Medicare Supplement & Portability members

Use this form to enroll in or make changes to your AutoPay account.

Introducing “AutoPay”

Simplify paying your monthly premiums by having payments made directly from your bank account to LifeWise Health Plan of Oregon. By automatically deducting your premium, AutoPay ensures timely payments, preventing a possible lapse in coverage or cancellation. There is no trip to the post office and no check to write. Your payments are taken care of even if you're out of town. You'll find that AutoPay is a great opportunity to save you both time and money.

It's easy to enroll on our AutoPay payment plan

Simply complete, sign and date the AutoPay Authorization Agreement on the back of this form. Be sure to attach a voided check or deposit slip. Then mail it to us at LifeWise, Attention: Membership & Billing, PO Box 7709, Bend, Oregon 97708-7709.

Does the automatic payment deduction start immediately?

Once we receive your AutoPay Authorization Agreement, it may take two to three months to process this information through your bank. You will receive monthly billings in the mail during this time. Simply make your payments directly to LifeWise until AutoPay is effective. This will help prevent the possibility of cancellation due to non-payment.

It's easy to update and request changes on your AutoPay account

To update your AutoPay account information, simply complete, sign and date the Authorization Agreement and return it to LifeWise. Be sure to attach a new voided check or deposit slip. We will update your account for the following month's automatic withdrawal as long as we receive the form by the 20th of the month.

Try our AutoPay option and simplify your payments. This option is offered as a convenience for all LifeWise Individual, Medicare Supplement and Portability members.

For more information about AutoPay, please call 1-800-596-3440 or visit our Web site at www.lifewiseor.com.

Individual, Medicare Supplement & Portability AutoPay Authorization



HEALTH PLAN OF OREGON

Automated Monthly Bank Withdrawal Authorization Agreement

Use this form to enroll in or make changes to your AutoPay account.

I hereby authorize LifeWise to initiate funds transfers for the amount of monthly premium for policy coverage from my bank account indicated below and authorize my bank to honor these transfers.

| | |
|---------------------------------------|------------------------|
| POLICYHOLDER'S NAME | |
| POLICYHOLDER'S ADDRESS | |
| POLICYHOLDER'S SOCIAL SECURITY NUMBER | LIFEWISE POLICY NUMBER |

Choose the appropriate statement below:

I wish to enroll onto AutoPay

Premium payments will be deducted each month on the 3rd working (business) day, or first banking day following any holiday. The deduction will also include any outstanding balance on my account. I have the right to stop payment of a transfer from my bank account to LifeWise. I must notify my bank at least three business days before the scheduled payment date. I understand that in order to stop a draft from being processed through my account, I must notify LifeWise no later than the 20th of the month to be effective for the following month's automatic withdrawal. I agree to indemnify and hold harmless LifeWise for any claim arising out of transfers or deductions from my account pursuant to this agreement. I understand it may take two to three months to process this form through my bank. I agree that until then, I will continue to submit the monthly premium payment directly to LifeWise.

Please change my AutoPay account

LifeWise agrees to discontinue drafting from your current account and begin drafting from the account listed on the voided check/deposit slip attached below. Change requests are effective the 1st of the month. Notification must be received by LifeWise no later than the 20th of the month preceding the date of change.

Please discontinue AutoPay from my policy

Please complete the following, then sign and date below:

| | |
|--|------------|
| NAME ON BANK ACCOUNT (Please print as it appears on your bank account) | |
| SIGNATURE of BANK ACCOUNTHOLDER | |
| ACCOUNT FUNDS TRANSFERRED FROM: <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS (Please check only one) | |
| <u>I affirm that premiums for this policy are not paid or sponsored by an employer.</u> | |
| SIGNATURE of POLICYHOLDER _____ | DATE _____ |

Please attach a voided check for checking or deposit slip for savings here.

Mail this completed form to: LifeWise, Attention: Membership & Billing, P.O. Box 7709, Bend, OR 97708-7709