Pay your monthly eternalHealth Medicare Advantage premiums quickly and easily!

Payment by automatic bank draft means:

- You do not have to write any more premium checks.
- eternalHealth will deduct the premium from your bank account by the 10th of each month.
- You don't have to worry about your checks getting lost in the mail.
- Your monthly premium will be paid automatically.
- Your premium will be paid even if you are out of town.

What you need to do to authorize automatic bank draft:

- Complete the automatic bank draft authorization form below.
- If you and your spouse are both enrolling in automatic payments, complete a form for each of you.
- While not required, we would appreciate you including a voided check.
- The below form must be received in our office no later than the last day of the month in order for the automatic withdrawal to begin the following month.

Note: *Your bank account must have sufficient funds to pay for the exact dollar amount of the premium on the agreed-upon payment date. If there are insufficient or uncollected funds in your account on the payment date, your bank will return the preauthorized payment and may charge you a returned check fee.*

If you have any questions, please call Member Services department at 1-800-680-4568 TTY users should call 711. October 1 - March 31, 8 a.m. to 8 p.m. ET, 7 days a week or April 1 - September 30, 8 a.m. to 8 p.m. ET Monday through Friday, 10 a.m. to 2 p.m. ET, Saturday.

Automatic Bank Draft Authorization

By signing this form, I permit eternalHealth to deduct a monthly premium amount of ___ from the bank account indicated below. I understand that if my premium were ever to change, eternalHealth would notify me first. I understand that I must notify eternalHealth and my bank in writing if I want them to stop deducting from my account. I understand I should notify eternalHealth if my account information changes.

Member name: _____ Member ID Number: _____

Address:_____ City: _____

State:_____ ZIP:_____

Phone:_____

Email address:_____

Bank or Financial Institution:_____

Bank Account Number:_____

Bank Routing Number: _____

Please circle one: Checking Account **or** Savings Account

Signature of account holder: _____Date:_____

Return Completed form to: Enrollment Department

eternalHealth
PO Box 621
Southborough, MA 01772