MediQ65®
Medicare Supplement Insurance from QualChoice

Payment Authorization Form

Select one of the four payment methods below.

☐ **Monthly Paper Bill:** I authorize QualChoice to bill my Medicare Supplement Insurance premium on a monthly basis. *Your monthly invoice will be mailed to your Billing Address as listed in Section I.*

☐ **Quarterly Paper Bill:** I authorize QualChoice to bill my Medicare Supplement Insurance premium on a quarterly basis. Your quarterly invoice will be mailed to the Billing Address as listed in Section I. ***NOTE:*** *Rates may change during the year. You may receive a credit or have to pay the rate difference at the end of the quarter.*

☐ **Annual Paper Bill:** I authorize QualChoice to bill my Medicare Supplement Insurance premium on an annual basis. ***NOTE:*** *Rates may change during the year. You may receive a credit or have to pay the rate difference at year-end.*

☐ **Monthly Bank Draft** ☐ **Quarterly Bank Draft** ☐ **Annual Bank Draft:** I authorize QualChoice to draft the checking/savings account listed below for my Medicare Supplement Insurance premium. This authorization is valid until I give written notice of cancellation to QualChoice 20 days before the bank draft withdrawal date. If I cancel my bank draft after agreeing to it, I will also be terminating my coverage, unless I send written notice to QualChoice of my desire to continue coverage at least 20 days before the bank draft withdrawal date. If my bank rejects a draft due to insufficient funds, QualChoice may charge me a fee of up to $20.00. If my bank draft is rejected, with or without cause, whether intentionally or inadvertently, QualChoice will have no liability even though such may result in the cancellation of my coverage.

Your first month's premium will be drafted upon acceptance of coverage. For all other premiums, please check one of the two bank draft dates below. **Example:** *Premiums due in January coverage month can be drafted on the 24th of December* **or** *the 5th of January.*

Please check (✓) one: ☐ **24th** of the month preceding the coverage month ☐ **5th** of the coverage month

Name of Bank or Financial Institution	Account Type (Check One) ☐ Checking ☐ Savings
Bank Account Number	9 Digit Bank Routing No.

Account Holder Name	Billing Address	City	State	Zip

Account Holder Signature X	Date Signed (MM/DD/YYYY)

Authorized Signature

By signing below, I agree to all terms and conditions stated in the payment method checked above. This payment method is valid until QualChoice gets written notice of my wish to change my payment method 20 days before my next premium due date. I understand that not properly following what has been authorized on this form may cause my Medicare Supplement Insurance policy to be terminated at QualChoice's discretion.

Print Name of Applicant	**Member ID**	**Signature of Applicant** X	**Date (MM/DD/YYYY)**

Send payment method changes to:
QualChoice, Attn: Finance | P.O. Box 25610 | Little Rock, AR 72221 or Fax: 501.707.6728
Questions: Please call 501.228.7111 ext. 7023 or 800.235.7111 ext. 7023