OptimaHealth

BusinessEDGE℠

Finance/Premium Billing Department
4456 Corporation Lane, Virginia Beach, VA 23462
Ph: 1 866- 472-5764 or 757 687-6400 Option 1
Fax: 1 866-635-2858 or 757 963-0168

Instructions: Please complete sections **A, B, & C** of the authorization for Automatic Payment Withdrawal form, along with a **voided check,** and return it to the mailing address or fax noted above. Below are some basic instructions to help complete this form.

Group Number: Listed at the top of your monthly premium statement. Please contact your Account Service Representative to assist you if you are unsure of your group number(s).

Authorized Representative: This is the name of the person who is authorized to make any banking transactions on your behalf and answer any questions related to your health insurance account.

Payment Date: Premiums are due the 26th day of the month prior to the month of coverage.

Payment Amount NEW: The amount of your premiums for the upcoming month plus any past due premiums, if applicable, will be deducted from your account. You will receive an invoice approximately 2 – 2 ½ weeks prior to your account being debited. If you are in disagreement with this amount, please notify your Account Service Representative at the number listed on your invoice. **Changes to your invoice must be received prior to the 5th of each month prior to the month due to adjust the auto-debit amount. Changes should be faxed to (757)963-0168 to our enrollment department for processing. You may contact our enrollment department at (757)687-6400, Option #2 for assistance. Adjustments will be noted on a future invoice for any changes that are not processed prior to the 5th of the month.

Financial Institution: The complete name and location of the banking institution where your funds will be debited. Your bank must be an ACH member in order to receive ACH transactions. Provide the contact name and telephone number of someone at your bank that Optima Health may contact with any questions.

Transit/ABA Number: This is a unique 9-digit number assigned to your financial institution. This information can be obtained from your bank or by looking at the lower left corner of your preprinted checks.

Account Number: The complete number of your checking account from which premium payments will be withdrawn.

****Reminder note:** All changes or cancellations to your banking information must be reported to us within 15 days prior to the deduction of your payment to prevent a withdrawal from being processed incorrectly. **You may fax your updated banking information or cancellation of auto debit requests to (757) 963-0168 as soon as you are aware that a change is needed.**

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Authorization for Automatic Payment Withdrawals

Section A

Proposed start date: _____

Group Name: _____

Group Address: _____

Group Number**(s)** _____

BE SURE ALL DUAL OPTION GROUP NUMBERS ARE LISTED

Phone Number: ( ) _____

Authorized Representative: _____

Section B

Financial Institution Name: _____

City, State, Zip Code: _____

Bank Contact Name: _____

Authorized Banking Signature: _____

Transit/ABA Number: _____

Account Number: _____

Note: *Optima can only debit Checking Accounts at this time.*

****Please attach a voided check with this form.****

Section C

I hereby authorize Optima Health Plan and/or Optima Health Insurance Company, to initiate debit entries to my checking account listed above, herein after called BANK, to debit the same to such account around the 26th day of each month prior to the month of coverage. I understand that any outstanding balances on my health insurance account will be deducted from my account. I further understand that any changes in status of my account, if not received by Optima Health on or before the 5th of the month, may not be changed in the month that is requested and will not be reflected until the next billing cycle. **(Changes should be faxed to (757)963-0168.<----------HERE**

This authority is to remain in full force and effect until BANK has received written notification from me of it's cancellation in such time and such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notification to BANK prior to charging account. After account has been charged, a customer has the right to have the amount of an erroneous debit immediately credited to his account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever occurs first. If there are insufficient funds at the time of debit, the company will be responsible for a $25.00 processing fee.

Name(s) of Authorized Representatives: _____

Authorized Signature: _____ Date: _____