Group Health Cooperative of South Central Wisconsin

Please review both sides of document for your payment options.

Initial Down Payment for Individual or Medicare Application Payment

Member Name (Print) _____ Member Number _____ (If known)

Phone Number _____

Credit Card

☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name _____

Card Number _____

Expiration Date _____

Billing Address for this Credit Card

_____

_____

Reminder this is a onetime payment deduction

By signature below, I (we) authorize Group Health Cooperative of South Central Wisconsin (GHC-SCW) to instruct my financial institution to deduct my premium payment from the account designated above. I authorize the financial institute to debit the amount of my premium from my designate account. This authorization is a onetime deduction only.

If you would like to set up automatic monthly payments please complete the Automatic Payment Authorization for Medicare Select or Individual Policies which is on the back side of this form.

SIGNATURE _____ DATE _____

Mail to:
GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN, ATTN: PREMIUM BILLING,
1265 JOHN Q HAMMONS DRIVE, MADISON, WI 53717

Neither GHC-SCW nor its agents are connected with Medicare

Group Health Cooperative
of South Central Wisconsin

To set up monthly automatic deductions for your premium payments, please complete this side of form. This does not include the initial payment for the application.

Automatic Payment Authorization for Medicare Select or Individual Policies

Automatic Payment Authorization (APA) is a convenient option for making monthly premium payments. APA allows Group Health Cooperative of South Central Wisconsin (GHC-SCW) to automatically transfer funds from your bank account, or charged to your Visa, MasterCard, or Discover Card to the amount due for premium. Forms must be signed and received by GHC-SCW **by the 10th** of the month. **Premium deductions occur on the 20th of each month.**

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

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Please complete the information below:

Member Name (Print) _____ Member Number _____

Checking/ Savings Account

☐ Checking ☐ Savings

Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____

****MUST INCLUDE A CHECK FOR THE FIRST MONTH PREMIUM****

Credit Card

☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

Billing Address for this Credit Card

_____

_____

☐ I **do not** want to receive paper copies of my monthly statement

By signature below, I (we) authorize Group Health Cooperative of South Central Wisconsin (GHC-SCW) to instruct my financial institution to deduct my premium payments from the account designated above. I authorize the financial institute to debit the amount of my premium from my designate account. This authorization is to remain in full force and in effect until GHC-SCW and depository have received written notification from me (us) of its termination within 30 days of termination date.

SIGNATURE _____ DATE _____

SIGNATURE _____ DATE _____

You may send this form along with your application or by mail to:
GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN, ATTN: PREMIUM BILLING,
1265 JOHN Q HAMMONS DRIVE, MADISON, WI 53717

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