Automatic Payments Authorization Agreement

Easy Pay from Experience Health for Medicare monthly premium costs

Member Name:	Member ID:
Bank Name:	Account Type: ☐ Checking ☐ Savings
ABA/Routing Transit #:	Account #:
Account Holder's Name:	
Account Holder's Authorized Signature:	Date:

Mail this form AND a voided check to:
Experience Health
Attn: Finance
PO Box 30010
Durham, NC 27702

If you have any questions please call Customer Service at 833-777-7394 between 8 a.m. and 8 p.m., 7 days a week. TTY users should call 711.

Important Information:
By signing this form, I certify that I am an authorized user of this bank account. I have chosen the Bank Draft Option as a convenience to me. I hereby request and authorize Experience Health to initiate the debit to my bank account payable to the order of Experience Health.* I agree that Experience Health's rights in respect to each bank draft shall be the same as if it were a check drawn on my bank account, and signed by me personally. I also authorize the financial institution to reduce the balance of my bank account by the amount of the bank draft. This authorization will remain in effect until I revoke it in writing at least 30 days prior to the date the account is scheduled to be charged. I agree that if such charges be dishonored, whether with or without cause and whether intentionally or inadvertently, Experience Health shall have no liability whatsoever even though dishonor results in forfeiture of insurance. Experience Health may attempt to debit my bank account up to three times for each month's premium to ensure no lapse in coverage. Please note that the use of an employer account requires the authorization of an authorized user of the account.

Footnote:
* Experience Health does not charge a fee for this service; however, your bank may charge a fee.

Experience Health is an HMO plan with a Medicare contract. Enrollment in Experience Health depends on contract renewal.

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