

MVP Gold and MVP GoldAnywhere Direct Payment Plan

MVP Gold & MVP GoldAnywhere are pleased to offer the Direct Payment Plan. Now you can have your health benefit premiums deducted automatically from your checking account.

Here's how the Direct Payment Plan works:

You authorize regularly scheduled payments to be made from your checking account. **Your payments will be made automatically by the fifth business day of each month;** proof of payment will appear on your statement. The authority you give to charge your account will remain in effect until you notify us in writing to terminate the authorization. Your payment amount will be for the exact amount of your monthly bill. The Direct Payment Plan is dependable, flexible, convenient and easy. To take advantage of this service, complete the authorization form and return it to us.

All you need to do is:

1. Fill in your name and financial institution information, and sign where indicated.
2. Attach a voided check for verification of all financial institution information.
3. Mail your signed and completed form to:

**MVP Health Care
Attn: Accounts Receivable Department
625 State Street
Schenectady, NY 12305**

4. MVP Health Care will mail a letter of confirmation that your information has been received and indicate the date the first auto debt will take place. Until then please continue to remit your monthly premium payments by check.
5. Please don't forget to sign and date the application and include a copy of a voided check.

Signing up is that easy.

If you have any questions, please call Member Services. Representatives are available Monday – Friday from 7:00 a.m. to 8:00 p.m. Eastern Time at (800) 209-3945. TTY users may call (800) 662-1220. From November 15 – March 1, representatives also are available weekends from 8:00 a.m. to 8:00 p.m.

**MVP Gold and MVP GoldAnywhere
Direct Payment Plan Authorization Form**

MEMBER INFORMATION:

Member Name (Please Print)

Street Address

City / State / Zip

Daytime Phone Number

AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize **MVP Health Care** to withdraw by the fifth business day of each month the amount due to MVP Health Care for the provision of health benefits. In the case of an automatic bank debit form of payment, it shall be the Customer's responsibility to verify whether these payments are properly debited to their bank account, and the Customer will undertake to notify MVP Health Care of any change in information relating to the Customer's bank account for purposes of ensuring the proper application of payments. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until I have cancelled it in writing to **MVP Health Care**.

Financial Institution Name (Please Print)

Checking Account Number at Financial Institution

Financial Institution Routing/Transit Number

Financial Institution City and State

Signature / Date

PLEASE KEEP A COPY OF THE AUTHORIZATION FOR YOUR RECORDS

Staple Voided Check Here
