Authorization For Automatic Funds Withdrawal For COBRA And Direct Bill Premiums

Please mail completed form to:
HealthSmart Benefit Solutions ■ P.O. Box 2981 ■ Charleston, WV 25330
Toll Free 877.517.6370 ■ TDD 877.517.6416 ■ Fax 855.841.0120

Here's how the Automatic Funds Withdrawal Process works:

You authorize regularly scheduled payments for COBRA and Direct Bill Premiums to be made from your checking or savings account. Your payments will be made automatically on the 5th day of the month and proof of payment will appear with your statement.

The authority you give to charge your account will remain in effect until you notify us in writing to terminate the authorization.

To take advantage of this service, complete the attached authorization form and return it to us.

Contact Information

Plan Name: AlaskaCare
Group Number: ○ 5851 Active ○ 5852 Retiree
Member ID (required)

Name (First, Middle Initial, Last)

Address | City | State | ZIP

Home Phone Number (Include area code) | Work Phone Number (Include area code)

Automatic Funds Withdrawal Set-up/Account Change/Cancellation Request

(Complete this section to implement new automatic withdrawal service, to change an existing automatic withdrawal account or to cancel automatic withdrawal service.)

Select One Of The Following:

○ Set-up Automatic Funds Withdrawal For COBRA Premiums
○ Change Automatic Funds Withdrawal Account For COBRA Premiums
○ Cancel Automatic Funds Withdrawal Account For COBRA Premiums
○ Set-up Automatic Funds Withdrawal Account For Direct Bill Premiums
○ Change Automatic Funds Withdrawal Account For Direct Bill Premiums
○ Cancel Automatic Funds Withdrawal Account For Direct Bill Premiums

Select One Of The Following: ○ Checking Account ○ Savings Account

Effective Date of Action

Bank/C.U. Routing Number (9 digits)

Personal Account Number (As it appears on check)

For changes to your account information please provide the following:

Old Routing Number

Old Account Number

I authorize HealthSmart Benefit Solutions to initiate electronic entries to my checking/savings account. I may revoke this authorization at any time by notifying HealthSmart Benefit Solutions.

Initial Payment Amount. (In the event that the payment amount changes we will notify you.

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Authorized Signature For Automatic Withdrawal of Premium Implementation/Account Change/Cancellation Request

Member's Signature | Date

We recommend attaching an original or photocopy of a voided check.