OptimaHealth

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Optima Health - Finance
4456 Corporation Lane, Suite 336
Virginia Beach, VA 23462
Phone: 1-800 275-3755
Fax: (757) 252-8038

Instructions: Please complete sections **A, B, & C** of the authorization for Automatic Payment Withdrawal form. Please email the completed form to IPFINANCE@sentara.com or fax to (757) 252-8038. Below are some basic instructions to help complete this form.

Member 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 member 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.

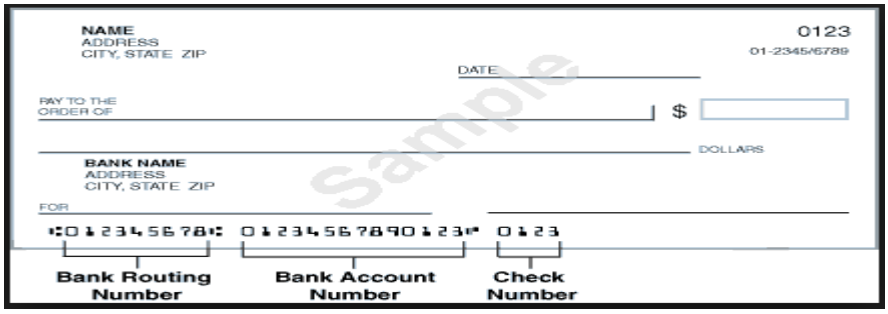
Payment Date: Premiums are due the first of the month for the covered period and will be deducted between the 5th and 8th business day of the month they are due.

Payment Amount: The amount of your premiums for the current month plus any past due premiums, if applicable, will be deducted from your account. You will receive an invoice approximately 10 days prior to your account being debited.

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.

Routing 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Account Number: The complete number of your checking account from which premium payments will be withdrawn. ***Please note we do not process Auto Debit from Business Checking Accounts.***



****Reminder note:** To ensure proper withdrawal and to avoid processing delays, all changes or cancellations to your banking information must be reported to us 15 days prior to the deduction of your payment. **You may email IPFINANCE@sentara.com or fax your changes or cancellations requests to (757) 252-8038 as soon as you are aware that a change is needed.**

Authorization for Automatic Payment Withdrawals

Section A

Proposed start date: _____

Member Name: _____

Member Address: _____

Member Number(s) _____

Phone Number: ( ) _____

Authorized Representative: _____

Section B

Financial Institution Name: _____

City, State, Zip Code: _____

Bank Contact Name: _____

Routing Number: _____

Account Number: _____

Note: *Optima can only debit Personal 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 between the 5th and 8th business day of each month. 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 15th 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) 252-8038.)**

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, you may be responsible for a $25.00 processing fee.

Name(s) of Authorized Representatives: _____

Authorized Signature: _____ Date: _____

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