



## AUTOMATED MONTHLY PREMIUM COLLECTION ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION FORM

To pay your plan premium by Electronic Funds Transfer (EFT) each month, please complete and return this form to KelseyCare Advantage. Automatic withdrawals will be processed on or around the 5<sup>th</sup> of every month.

| Member Information |  |                 |  |
|--------------------|--|-----------------|--|
| Member Name        |  | Medicare Number |  |
| Address            |  |                 |  |
| City, State Zip    |  |                 |  |

| Banking Information                    |  |
|--|--|
| Bank Name                              |  |
| Account Holder Name                    |  |
| Account Number                         |  |
| Bank Routing Number                    |  |
| From Checking <input type="checkbox"/> | Please Attach a Voided Check to this Form        |
| From Savings <input type="checkbox"/>  | Please Attach a Voided Deposit Slip to this Form |

I hereby authorize KelseyCare Advantage to begin withdrawing premiums from my bank account as shown above. I understand that I have a right to stop the automatic deduction by notifying my bank at any time or by written notification to KelseyCare Advantage. I understand this agreement will remain in effect until KelseyCare Advantage has received written notice from me. I agree to notify KelseyCare Advantage promptly if I change and/or cancel banks or the bank account listed above. I understand if I cancel Electronic Funds Transfer, I will receive a bill for my plan premium each month from KelseyCare Advantage.

Member Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

If you have any questions, please feel free to contact us at (713) 442-2273 or (866) 535-8343. TTY users can call 711. Hours are October 1st – March 31st, 7 days a week from 8 a.m. to 8 p.m. & April 1st – September 30th, Monday – Friday from 8 a.m. to 8 p.m. Messaging services used weekends, after hours and on federal holidays.

Please mail the completed form with your voided check/deposit slip to:

**KelseyCare Advantage**  
**P.O. Box 841569**  
**Pearland, Texas 77584**

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