## **Authorization Agreement for Automatic Bank Withdrawal**

For Your Monthly Premium Payment

3816 S. Elmwood Ave., Suite 100 Sioux Falls, SD 57105-6538



Important

	NOTE: The automatic bank withdrawal will take
•	place on or around the fifth day of each month.
automatic bank withdrawal information.	You may cancel your automatic bank
Start (add) Authorization	withdrawals at any time. We must receive your
Update Authorization	written notification at least 20 days before your
	next scheduled bank withdrawal.
	FORMATION
• • •	COBRA Employer Group
	,
BANKING INFO	RMATION
Bank name:	
. Name on bank account:	
NOTE: Your routing number is located on your check, if n	ot available, please contact your bank.
re a one-time electronic debit entry nom my account to con	eol a balik letalli lee ol 425.
	<del>_</del>
nature of authorized bank account holder	Date
nature of authorized bank account holder NAL STEPS: Mail or fax completed form and end	
	Start (add) Authorization  Update Authorization  Stop (cancel) Authorization  Identify the date you are requesting to implement:  (MM/YY)  POLICYHOLDER IN  Identify type of insurance plan. Check One: Individual Medicare Supplement Policyholder name: Or employer group plan name: Policy or member number: Or Social Security Number: Email Address:  BANKING INFO  Check one: Checking account or Savings accound Bank name: Bank resides in city: Name on bank account: Bank account number: NOTE: Your routing number is located on your check, if number is located on your check, if number is located on your check, if number is located Clearing House (ACH) debit entries from my check mium payments, and if necessary, credit entries from my check mium payments, and if necessary, credit entries due to over the above designated bank account. This authorization will now in an and my financial institution a reasonable opportunity to a larges to the banking information that I have provided. I acknown account must comply with the provisions of the U.S. law. I werage ends, or my automatic debit rejects for insufficient further and the continued of the continued electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic debit entry from my account to collected on electronic

Please enclose a voided check or copy of a check.

## Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

## Avera Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the Avera Health Plans Service Center at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that Avera Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Complaint and Appeals Coordinator Avera Health Plans 3816 S. Elmwood, Suite 100, Sioux Falls, SD 57105-6538

Fax 1-800-269-8561 Email ComplaintAppeals@AveraHealthPlans.com You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

US Department of Health and Human Services, 200 Independence Avenue SW Room 509F, HHH Building, Washington, D.C. 20201

Complaint forms are available at <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>.



## **Getting Help in other Languages**

Language assistance services are available free of charge. Our Service Center is available 8 a.m. to 5 p.m. CST, Monday – Friday, toll-free at 1-888-322-2115 (TTY: 1-800-877-1113).

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- US CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- XIYYEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- 注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-888-322-2115 (TTY: 1-800-877-1113).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (телетайп: (ТТҮ: 1-800-877-1113).
  - ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-2115-382 (رقم هاتف الصم والبكم: 1-1113-878-880)
- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ဟ်သူဉ်ဟ်သ:– နမ့်ကတိုး ကညီ ကျိဉ်အယိ, နမၤန္၊ ကျိဉ်အတါမၤစာၤလ၊ တလာဉ်ဘူဉ်လာစ္၊ နီတမီးဘဉ်သန္ဦလီး. ကို:1-888-322-2115 (TTY: 1-800-877-1113).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (TTY: 1-800-877-1113).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-322-2115 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- ማስታወሻ: የሚናሉት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሲያንዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁተር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: 1-800-877-1113)
- OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113)
- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-322-2115 (TTY: 1-800-877-1113)។