

**NEW HAMPSHIRE HEALTHY KIDS  
AUTHORIZATION FOR AUTOMATED PREMIUM PAYMENTS  
SILVER PROGRAM**

I (we) hereby authorize NEW HAMPSHIRE HEALTHY KIDS to initiate automatic withdrawal of my (our) premium payment on the 30<sup>th</sup> of each month in the amount of my monthly health insurance premium from my (our)

checking \_\_\_\_\_ or savings \_\_\_\_\_ (check one)

account indicated below and for the bank named below to debit the same to such account:

YOUR BANK'S NAME \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

ROUTING # \_\_\_\_\_ (this is the 9 digit # just before your account number on the bottom of your check)

ACCOUNT # \_\_\_\_\_

**ATTACH VOIDED CHECK FOR CHECKING ACCOUNT WITHDRAWALS**

This authorization is to remain in full force and effect until NEW HAMPSHIRE HEALTHY KIDS has received written notice from me (or either of us) of our wish to end the automated premium withdrawal. Such notification must be received 10 days prior to the next withdrawal date in order to allow NEW HAMPSHIRE HEALTHY KIDS and THE BANK a reasonable opportunity to act on it.

**\*\* If the 30<sup>th</sup> falls on a holiday or weekend, your payment will be processed on the last business day prior to the payment date.**

NAME \_\_\_\_\_ SIGNED \_\_\_\_\_

NAME \_\_\_\_\_ SIGNED \_\_\_\_\_

DATE \_\_\_\_\_ HEALTHY KIDS CUSTOMER ID# \_\_\_\_\_

Please call our Accounting Department toll free at 1-877-464-2447 or 228-2925, ext. 241 if you have any questions. This form must be returned at least ten days prior to the 30<sup>th</sup> in order to begin automated payments for that month. In the meantime, you are responsible for any outstanding premiums.

## **NEW HAMPSHIRE HEALTHY KIDS AUTOMATED PREMIUM PAYMENTS SILVER PROGRAM**

We are pleased to notify you about a payment option that automatically deducts your premium payment from your designated bank account each month. We encourage you to enroll in the automatic payment plan. This easy way to make your payment will save you time and eliminate your receiving calls and letters for late payments. It will also help keep our administrative costs low so we can keep premiums as low as possible.

### **To enroll in the automatic payment plan, please complete the following step:**

- Fill out this authorization form and return it to NHHK 1 Pillsbury Street Suite 300 Concord, New Hampshire 03301-3556. Your authorization must be received at least 10 days before the payment date. In the meantime, you are responsible for any outstanding balance on your account.

### **Additional information you should know about automated payments:**

- If your premium changes, you do not need to complete a new form. We will automatically update the amount we are deducting from your bank account.
- If at any time your bank balance does not cover your payment, you may be charged a non-sufficient funds fee. You will then be responsible for mailing your missed payment to us.
- The automatic payment covers the upcoming month of coverage. In other words, we will subtract your payment for January benefits on December 30<sup>th</sup>.
- If the 30<sup>th</sup> of the month falls on a holiday or weekend, your payment will be processed on the last business day prior to the payment date.
- If you want to stop the automated payment deduction, you must let us know in writing 10 days before your next payment date.

We strongly encourage you to enroll in our automated premium payment plan. If you choose to participate, please send in your authorization form as soon as possible but at least 10 days before the payment date. If you have questions about this payment option, please contact our Accounting Department at 228-2925 or toll free at 1-877-464-2447, Ext. 241.

**Please retain this page for your records**