Ready to start automatic payments?

Indiana State Medical Association offers insurance subscribers the opportunity to make automatic payments for their ISMA-sponsored Anthem Medicare Supplement premiums directly from their checking accounts.

When you sign up for the Direct Payment Via ACH Plan, your Anthem health insurance premiums will automatically be deducted electronically from your bank account on the 25th day of each month (or the first business day thereafter) for the following month's premiums.

To join the Direct Payment Via ACH (ACH Debit) Plan:

1. **Read the Terms and Conditions on the ACH Authorization Form on the reverse side**
2. **Complete and sign the form**
3. **Return the form to us with a voided check or a photocopy of a voided check (to allow us to verify the bank routing number and account number)**

ISMA will continue to issue paper invoices but they will be clearly marked DO NOT PAY, FOR YOUR RECORDS ONLY.

Please call the ISMA Health Insurance Team at (317) 217-1550 if you have any questions.

ISMA
INDIANA STATE MEDICAL ASSOCIATION

322 Canal Walk • Indianapolis, IN 46202-3268
(317) 261-2060 • Toll free: (800) 257-4762 • www.ismanet.org

ISMA-sponsored Health Insurance

Authorization for Direct Payment Via ACH (ACH Debit)

Direct Payment Via ACH is the transfer of funds from a consumer account for the purpose of making a payment.

I (we) agree that ACH transactions I (we) authorize comply with all applicable law. I (we) authorize the Indiana State Medical Association to electronically debit my (our) account (and, if necessary, electronically credit my (our) account to correct erroneous debits) as follows:

Name of Account Holder _____

☐ Personal Checking Account ☐ Business Checking Account (select one)

Financial Institution Name/City/State _____

Routing # _____ Account # _____

Preferred Bill Cycle ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

To assist in verifying this account, please attach a voided check or a copy of a cleared check previously issued to the Indiana State Medical Association paying insurance premiums from this account.

I (we) authorize debit of the balance owed as reflected on the Group Health Insurance Billing Statement to be processed on the 25th day of the month prior to the month(s) of coverage, or on the next business day. I (we) understand that if any payment is returned by the Financial Institution for any reason, I (we) will be responsible for NSF and/or administration charges.

I (we) understand that this authorization will remain in full force and effect until I (we) notify the Indiana State Medical Association in writing by mail to the address above or by fax to (317) 261-2238 that I (we) wish to revoke this authorization. I (we) understand that the Indiana State Medical Association requires at least 3 weeks prior notice to cancel this authorization.

Name of Authorized Signer _____ Date _____

Signature of Authorized Signer _____

Email Address _____