



**Priority Health Medicare  
Automatic Bill Payment Enrollment Form**

**I authorize Priority Health to deduct my premium payment from the checking or savings account listed below. I understand the deduction will occur on the 1<sup>st</sup> of every month. If at any time I decide to discontinue this payment service, I will notify Priority Health in writing 30 days before discontinuing.**

Priority Health Contract Number (on ID card) \_\_\_\_\_

Policy Holder Name (Please Print) \_\_\_\_\_

Mailing Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone Number (with Area Code) \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

**If the withdrawal is from a checking account, please complete the following information – OR – attach a voided check.**

**If the withdrawal is from a savings account, you must attach a letter from your financial institution to verify account information.**

Name of Financial Institution \_\_\_\_\_

ABA/Routing Number (9 digits on bottom left-hand corner of check): \_\_\_\_\_

Account Number (set of numbers to right of routing number): \_\_\_\_\_

*There will be a \$50.00 charge for any transfers returned insufficient.*

**Please return this form to:**

**Priority Health, MS 1190  
1231 East Beltline NE  
Grand Rapids, MI 49525**