

Payment Election

I hereby authorize UPMC Health Plan, its affiliates, and its subsidiaries to deduct a one-time insurance payment from my account at the financial institution named below for the amount specified.

Signature: _____ Date: _____

Group Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Payment Amount: _____

Payment Method: (You must choose one.)

Electronic Bank Withdrawal

☐ Personal Checking Account

☐ Business Checking Account

☐ Personal Savings Account

☐ Business Savings Account

Name on Account: _____

Banking of Financial Institution Name: _____

Routing Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Account Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

OR Credit Card

☐ Visa

☐ Master Card

☐ Discover

American Express is not accepted

Name on Card: _____

Card Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Expiration Date:

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CVC Number:

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