SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN

3601 WEST OLIVE AVENUE, BURBANK, CA 91505 MAILING ADDRESS: P.O. BOX 7830, BURBANK, CA 91510-7830
(818) 954-9400 or (800) 777-4013 FAX (818) 953-9880
email: psd@sagph.org website: www.sagph.org

Application for Auto Debit from Bank Account

Enjoy the security of knowing that your premium is paid on time with the Health Plan's Auto Debit option.

Auto Debit deducts your premium automatically on a recurring basis from a U.S. checking or savings account. If you are on the Self-Pay program, have coverage under the Senior Performer Health Plan, or the Extended Spousal benefit, your payments will be deducted **monthly** on the 25th of the month prior to the due date. If you have Earned coverage, your premiums will be deducted quarterly on the 25th of the month prior to each quarter.

To get started, register at **www.sagph.org** and click on "Sign-Up for Auto Debit" or complete and sign the form on the reverse. Please be sure to include **all of the required bank information.**

- Savings account, verify both the routing and account numbers with your bank.
- Checking account, attach a copy of a voided blank check from that account.

Completed applications must be received in our office 15 days prior to the premium due date. Please note that enrollment in Auto Debit may be delayed if your premiums are not current.

As long as you are eligible for coverage the Health Plan will automatically deduct your premiums. This will occur regardless of changes in the premium rate, or benefit plan (e.g. going from Plan I to Plan II or the reverse if you are on Earned coverage).

A new Auto Debit application will need to be completed if coverage changes from Self-Pay to Earned or Earned to Self-Pay.

Advance notification will be sent in the event of any change in your eligibility status or premium rate. **A handling fee in the amount of $25.00 will be assessed on a declined Auto Debit transaction.**

Cancellation or change in bank account information requires **a written request** and must be received in our office 15 days prior to the premium due date. **No verbal requests will be accepted.**

Questions? If you have any questions regarding your premium payment options, please visit **www.sagph.org** or contact the Health Plan.

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Application for Auto Debit from Bank Account

☐ New Applicant ☐ Change *(Change in bank or account information)*

Participant/Extended Spousal Name: _____
Please Print

Participant SSN/NSA: _____ Auto Debit Effective Date: _____

AUTO DEBIT OPTION – Please check one only: ☐ Checking Account **(Attach voided check below)** ☐ Savings Account

NAME OF BANK: _____

BANK ADDRESS: _____

BANK ACCT.#: _____

ABA (ELECTRONIC ROUTING) #: _____

I, _____ authorize Screen Actors Guild-Producers Health Plan to
(Participant / Acct. Holder if not participant)
withdraw the scheduled monthly and or quarterly (whichever is applicable) Health Plan premium payment from my checking or savings account on the 25th of the month prior to the due date based on the information provided by me on this form. **I further authorize the Health Plan to adjust this withdrawal to reflect any rate change that may occur.** The Plan's authority is to remain in full effect until the Health Plan has received written notification from me of its termination or until the Health Plan has sent me a 10-day written notice of the termination of this agreement.

_____ _____
Participant's/Extended Spousal's Signature (required) Date

_____ _____
Acct. Holder's Signature (required if not Participant or Extended Spouse) Date

Auto Debit applies to U.S. bank accounts only

ATTACH VOIDED CHECK