

Union Pacific Railroad Employees Health Systems
PREMIUM PAYMENT OPTIONS & AUTHORIZATION INSTRUCTIONS
Return this completed Premium Option form and your completed Enrollment Application
To UPREHS in the enclosed postage paid envelope – Remember to sign both forms!

Monthly Premium Payment: After you pay your initial one-month premium of \$220, you may pay your premium monthly if you have the amount automatically withdrawn from your bank checking or savings account. We cannot accept monthly payments sent directly to UPREHS.

Quarterly Premium Payment: You may pay your premium quarterly (3 months at a time). Quarterly premiums can be made direct or via automatic bank withdrawals. If you elect quarterly premiums, include your initial payment of \$660 with your enrollment form and this authorization form for auto debits. Future premiums will be debited from your bank account quarterly.

For Automatic Bank Withdrawal, Complete this Authorization Form:

This form works for both you and your spouse if you are both enrolling. Return this completed form and your blank check with the word "VOID" written on it to UPREHS in the enclosed postage paid envelope along with your completed enrollment form. Do not send a deposit slip. For savings account payments, provide your account number and your bank's routing/transit number below.

- I want to make Monthly Premium Payments
- I want to make Quarterly (3 months at a time) Premium Payments

I/We (you may include your enrolled spouse in this authorization) hereby authorize UPREHS to initiate debit entries (withdrawals for premium payments) and any needed adjustment to my (our) account with my bank:

(Name of Bank) _____
(Bank routing/transit number if using savings)

(City) _____ _____
(State) (Zip)

(Saving account number if not using a checking account)

This authority is to remain in full force and effect until UPREHS has received written notification from me (us), or another authorized person on my (our) behalf of my (our) intent to terminate this authorization. However, I (we) realize that I (we) must give UPREHS at least 15 days advance notice of my (our) intent to terminate.

(Print Applicant Full Name) _____
(Medicare # From your Medicare ID Card)

(Print Spouse Full Name) _____
(Medicare # from your Medicare ID Card)

(Applicant Signature) _____
(Date Signed)

(Spouse Signature) _____
(Date Signed)

Telephone Number () _____ Email Address: _____