Martin's Point

US FAMILY HEALTH PLAN

Electronic Payment Authorization

1 **Please fill out the following account information:**

Name of subscriber: _____ ARAC#: _____

2 **Please select one of the following autopay options:**

ANNUAL PAYMENT – Amount due every January

☐ **Automatically Recurring** ☐ Credit or Debit card Card#: _____
Exp date: _____

☐ EFT DEduction Routing #: _____
Account #: _____
Bank name: _____ ☐ Checking ☐ Savings

☐ **Non-recurring** (You will receive a direct bill and must initiate payment)
☐ Credit or Debit card Card#: _____
Exp date: _____

QUARTERLY PAYMENT – Amount Due every January, April, July, and October

☐ **Automatically Recurring** ☐ Credit or Debit card Card#: _____
Exp date: _____

☐ EFT DEduction Routing #: _____
Account #: _____
Bank name: _____ ☐ Checking ☐ Savings

☐ **Non-recurring** (You will receive a direct bill and must initiate payment)
☐ Credit or Debit card Card#: _____
Exp date: _____

MONTHLY PAYMENT – Deducted automatically every month

☐ **Automatically Recurring** ☐ Credit or Debit card Card#: _____
Exp date: _____

☐ EFT DEduction Routing #: _____
Account #: _____
Bank name: _____ ☐ Checking ☐ Savings

☐ Allotment deduction (withdrawn from Retirement Pay)

3 **Please sign to authorize this automatic payment**

Member Signature: _____ Date: _____

Please return your completed form to:

USFHP Health Plan Premium Billing Department
Martin's Point Health Care
PO Box 9746
Portland, ME 04104