ISMA
INDIANA
STATE
MEDICAL
ASSOCIATION

322 Canal Walk • Indianapolis, IN 46202-3268
(317) 261-2060 • Toll free: (800) 257-4762 • www.ismanet.org

Indiana State Medical Association
Group Health Insurance
Authorization for Direct Payment Via ACH (ACH Debit)
Instructions

The Indiana State Medical Association offers insurance subscribers the opportunity to make automatic ISMA/Anthem health insurance premium payments directly from their checking accounts.

When you sign up for the Direct Payment Via ACH Plan, your Anthem health insurance premiums will be deducted electronically from your bank account on the 25th day of each month (or the first business day thereafter) for the following month's premiums.

To join the Direct Payment Via ACH (ACH Debit) Plan:

1. Print the attached Payment Authorization Form.
2. Read the Terms and Conditions
3. Complete and sign the form.
4. Fax it to us at 1-317-261-2238 with a copy of a voided check to allow us to verify the bank routing number and account number.

ISMA will email you to confirm enrollment. Once enrolled, ISMA will notify you when the premium amount changes.

Please call the ISMA Health Insurance Team at (800) 257-4762 if you have any questions.

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Direct Payment Via ACH is the transfer of funds from a consumer account for the purpose of making a payment.

I (we) agree that ACH transactions I (we) authorize comply with all applicable law. I (we) authorize the Indiana State Medical Association to electronically debit my (our) account (and, if necessary, electronically credit my (our) account to correct erroneous debits) as follows:

Insured ID or Master Insured ID (from billing statement) _____

☐ Personal Checking Account ☐ Business Checking Account (select one)

Name of Account Holder _____

Financial Institution Name/City/State _____

Routing # _____ Account # _____

To assist in verifying this account, please attach a voided check or a copy of a cleared check previously issued to the Indiana State Medical Association paying insurance premiums from this account.

I (we) authorize debit of the balance owed as reflected on the Group Health Insurance Billing Statement to be processed on the 25th day of the month prior to the month(s) of coverage, or on the next business day. I (we) understand that if any payment is returned by the Financial Institution for any reason, I (we) will be responsible for NSF and/or administration charges.

I (we) understand that this authorization will remain in full force and effect until I (we) notify the Indiana State Medical Association in writing by mail to the address above or by fax to (317) 261-2238 that I (we) wish to revoke this authorization. I (we) understand that the Indiana State Medical Association requires at least 3 weeks prior notice in order to cancel this authorization.

Name of Authorized Signer _____ Date _____

Signature of Authorized Signer _____

Email Address _____

FOR ISMA USE ONLY

_____ Date entered in banking and billing systems

_____ Date emailed confirmation