



**SIERRA HEALTH AND LIFE
INSURANCE COMPANY, INC.**
a subsidiary of Sierra Health Services, Inc.

PREMIUM PAYMENT OPTIONS	
(You must select one of the premium payment options below.)	
Your plan premium for the Part D Prescription Drug benefit is: \$ _____ Your <i>plan</i> premium for services covered under Medicare Parts A and B is: \$ _____. (You must still continue to pay Medicare Part B premiums, and/or part A premiums, if applicable.)	Check one
Direct payment by check or money order (check one): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/>
Automatic deduction from your Social Security, Railroad Retirement, or Office of Personal Management Payment.	<input type="checkbox"/>
Monthly Bank Draft (please complete the authorization below)	<input type="checkbox"/>

Monthly Bank Draft Authorization			
If you selected Monthly Bank Draft, complete the below to authorize payment.			
Applicant's Name:		Applicant's Social Security Number:	
Address: Street	City	State	Zip
Telephone Number (home):		Telephone Number (business):	
E-mail Address (home):		E-mail Address (business):	
Bank Name:		Bank Branch:	
Bank Address:			
Account Number:	Type of account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Account Holder Name (as it appears on bank records):	

I authorize Sierra Health and Life Insurance Company, Inc. (SHL) to initiate debit entries to the account listed above at the bank or credit union (institution) listed above **equal to the monthly premium**. This authorization is to remain in full force and effect until SHL and the institution have received written notification from me of its termination in such a manner as to afford SHL and the institution a reasonable opportunity to act on it. I have the right to stop payment of a debit entry by notification to the institution prior to charging the account. After the account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by the institution, provided I send written notice of the error to the institution within 15 days of the issuance of the account statement or 45 days after posting, whichever occurs first. Should this right be exercised, I will notify SHL prior to such action to make arrangements for continuation or termination of coverage. Your premium will be debited effective the _____ of every month.

Please note:

1. This application will not be processed without a **pre-printed voided check** from which monthly premiums are to be withdrawn.
2. In the event the monthly premium changes (after you have been notified), the new premium rate will be deducted from this account.

Signature of Depositor (as it appears on bank records) _____
Date

To receive this information in a different format, please contact the plan.