Samaritan Health Plans

ONE-TIME PREMIUM PAYMENT OPTION FORM

This form allows for a one-time only premium payment for your Samaritan Advantage Health Plan monthly premium. You will need to submit personal account information for our plan to process the one-time only premium payment. Please check the appropriate box and complete the information requested.

☐ **OPTION 1: One-Time Credit/Debit Card Premium Payment**

Credit/Debit Card Number: _____

Expiration Date: _____

Cardholder Name: _____

Cardholder Zip Code: _____

☐ **OPTION 2: One-Time EFT (Electronic Funds Transfer) Premium Payment**

☐ Checking ☐ Savings

Account Holder Name: _____

Account Number: _____

Routing Number: _____

Your signature verifies that you understand that you are voluntarily giving Samaritan Advantage Health Plan your account information for the sole purpose of making a one time plan premium payment.

PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW:

By signing this form, I hereby declare that Samaritan Health Plans has my permission to deduct my **Samaritan Advantage Health Plan (HMO) balance** from my personal account. I understand that Samaritan Health Plans will keep this information confidential.

_____ _____

Member Name Member ID#

_____ _____

Account/Cardholder Signature Date

_____

Print Name

Office Use Only: Member ID # _____ Start Date: _____

_____

2300 NW Walnut Blvd. | Corvallis, OR 97330