AmeriHealth NEW JERSEY

Individual Health Coverage Payment Form 2015

Payment options

AmeriHealth New Jersey offers various options for paying your premium. You can choose to make your **first monthly payment** by credit/debit card, or you can do a one-time ACH withdraw from your bank account.

Credit/Debit card

Please note that we will only accept Visa or MasterCard for credit/debit card payments, and you may only pay with a credit/debit card for the first month's premium.

Prepaid option

We are accepting all prepaid American Express, Visa, Master Card and Discover debit cards for your first month's premium.

INITIAL PAYMENT

Cardholder name: _____

Credit card type: ❑ Visa ❑ MasterCard

Prepaid: ❑ American Express ❑ Discover

Credit card number: _____

Security code: _____ Expiration date: _____

This 3 digit number can be found on the back of your card.

Cardholder's billing address: _____

City, State, ZIP: _____

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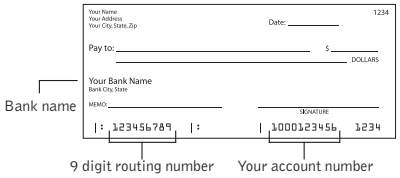
Automated payments through ACH

AmeriHealth New Jersey offers a free initial electronic one-time ACH withdraw. You authorize the withdrawal of your total premium amount due from your checking or savings account, and AmeriHealth New Jersey will deduct your payment through the ACH (Automated Clearing House) process.

Important instructions:

1. Complete and sign this form.
2. Attach a voided check (for checking accounts) or deposit slip (for savings accounts).
3. Return this form with your application.
4. **This form only collects your first monthly premium. To set up recurring monthly payments, log onto www.amerihealthexpress.com**.



Name on bank account:	
Bank routing/transfer number:	
Relationship to applicant:	
Bank account number:	
Name of financial institution:	
Type of account:	❑ Checking ❑ Statement savings (No passbook accounts)
Bank account usage:	❑ Personal ❑ Business

Account holder signature: _____ Date: _____

Additional signature (if joint account): _____ Date: _____

Signature of applicant: _____ Date: _____
(if different than account holder)

I (we) authorize my bank or savings institution to make payments to AmeriHealth New Jersey from the account listed above. I (we) understand this authorization may be revoked by me at any time, by written notification, to discontinue my automatic payment. I (we) agree to maintain sufficient funds in the account to permit these deductions. If the account does not maintain sufficient funds, electronic payments will be cancelled and I (we) will be billed through the postal service (regular mail).

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