



## Automatic Payment ACH

### Welcome to Prominence Health Plan!

This form provides authorization to draft your monthly premiums.

Please fill out the information below to have an ACH withdrawal for your initial and monthly payments.

Company Name \_\_\_\_\_  
Billing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal code \_\_\_\_\_  
Email Address \_\_\_\_\_

#### Monthly Premium Information

Initial Premium Payment Amount \$ \_\_\_\_\_

Bank Account Type: ☐ Checking ☐ Savings

Account Holder Name \_\_\_\_\_  
Routing Number \_\_\_\_\_  
Account Number \_\_\_\_\_

Credit Card payments (**on Hold until 2025**):

#### Authorization Agreement

I understand that by completing this form I am authorizing Prominence Health Plan to withdraw the **INITIAL PREMIUM PAYMENT AND SUBSEQUENT MONTHLY PREMIUMS** from my bank or credit card account. I understand that this payment will be deducted from my account within 1 to 2 business days after notification of group health plan approval and will be recurring monthly within 3 business days after the monthly bill is generated. For notification of credit card changes, please contact our billing department at 775-770-9345 or [PHP-PremiumBilling@uhsinc.com](mailto:PHP-PremiumBilling@uhsinc.com)

Name (Printed) \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_