Prominence® Health Plan

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

Name (Printed)_____ Title _____

Signature_____ Date Signed _____