ROCKY MOUNTAIN HEALTH PLANS®
Good health. That's the plan.

New Payment Options

Rocky Mountain Health Plans (RMHP) is pleased to announce we are now offering three different options for premium payment. Please check the box for the payment plan you wish to change to:

- ❑ **Quarterly Invoice Billing.** RMHP will mail you a quarterly premium billing invoice. This option requires pre-payment for the entire quarter. Quarterly payments are due the first business day of the month and the amount due is for the full three months.
- ❑ **Monthly Bank Draft.** RMHP can withdraw your monthly premiums directly from your bank account. With this option, no invoice is mailed and you do not have to worry about mailing your payment on time. *Simply complete the Account Deduction Authorization form and attach a voided check.*
- ❑ **Monthly Credit Card Automation.** RMHP can automatically request monthly payment from your credit card company. With this option, there is no invoice sent and you do not have to worry about mailing your payment on time. As an added convenience, **you only need to give us your Credit Card information and approval one time**. *Simply complete the credit card form below and check the box for* ***reoccurring billing***.

Thank you for your Membership with Rocky Mountain Health Plans.

Account Deduction Authorization

I, _____, authorize the monthly deduction of
(Print Name)
Rocky Mountain Health Plans premiums from my account _____
(Account Number)
at _____
(Bank Name) *(Location)*
for _____ .
(Subscriber name, if different) *(Subscriber Member Number)*

I understand that if the bank fails to remit my premium, my membership will not be terminated until I have been given the opportunity to pay the amount due.

Signature _____ Date _____

✔ **Please attach a voided check from your bank account.**

Credit Card Authorization

Use this form to pay the accompanying invoice with either VISA, DISCOVER, or MASTERCARD. Simply fill in the information requested. Then sign where indicated before returning this form with your invoice.

Member Name: _____ Member Number: _____

Name of Account Holder (if different from member name): _____

CREDIT CARD: ❑ VISA ❑ DISCOVER ❑ MASTERCARD ❑ AUTOMATED REOCCURING BILLING

Credit Card Number: _____ Expiration Date: Mo. _____ Yr. _____

X _____ $Amount: _____ Date: _____
Signature of Account Holder

RMHP Member in Colorado: PO Box 10600, Grand Junction, CO 81502-5600 — 970-244-7760 or 800-843-0719
WINhealth Partners Members in Wyoming: PO Box 60160, Grand Junction, CO 81506-3900 — 800-840-2211
Fax: 970-244-7769
8:00 A.M – 8:00 P.M. Mountain time, seven days a week
If you are hearing impaired and use TTY equipment, call 800-704-6370