McLaren
MEDICARE

ELECTRONIC FUNDS TRANSFER (EFT) PAYMENTS

McLaren Medicare administers EFT payments for health care premiums in the following manner:

- On the first business day of every month, your monthly premium will be automatically debited from your designated checking or savings account.
- You must notify McLaren Medicare of any changes to your designated account at least 15 days before the last day of the month.
- If there are insufficient funds in your account for the EFT to occur, you are responsible for any bank fees charged to McLaren Medicare. You will also be responsible for paying the monthly health care premium in a manner other than EFT.
- McLaren Medicare will only attempt the EFT once a month, on the first business day of the month.
- Please complete and sign the attached EFT consent form. Return the completed form to McLaren Medicare by one of the following options:
    - **Mail:** Attn: Finance Dept.
      McLaren Health Plan
      G-3245 Beecher Road
      Flint, MI 48532
    - **Fax:** 810-600-7947
    - **Email:** MHPFinanceDepartment@mclaren.org
- McLaren Medicare will send you a confirmation letter upon receiving your completed *EFT Payment Consent* form. The letter will confirm your request for your monthly premium payments to be made by EFT. Confirmation of the premium amount and the date of the first EFT will also be in this letter. Please continue to make your regular monthly premium payments until you receive this EFT confirmation letter.

If you have any questions regarding EFT payments, please call the McLaren Health Plan (MHP) finance department at 810-733-9795 Monday – Friday, 8:30 a.m. – 5 p.m. (TTY: 711.)

Sincerely,

MHP Finance Department

McLaren
MEDICARE

EFT PAYMENT CONSENT

Member Name: _____

Contract #: _____ Phone Number: _____

Address: _____

_____

I, _____ (print name), give permission for the MHP finance department to electronically withdraw the amount owing for the monthly premium payment from the bank account I have listed below. I certify that I am a legal signer on this bank account and can authorize this type of payment. This EFT withdrawal will be completed monthly on the first business day beginning in the month I've chosen below. If there are not enough funds available on the first business day of the month to complete this transaction, I understand that I am liable to complete the monthly premium payment in a manner other than EFT. MHP reserves the right to revoke this agreement at any time.

Bank Name: _____ Bank Routing #: _____

Bank Account #: _____ ☐ Checking ☐ Savings

Month to begin EFT premium payments: _____

Signature: _____ Date: _____

SUBMIT

McLaren Medicare
PO Box 710 Flint, Michigan • 48501-9900
tel 888-327-0671 (TTY: 711) • fax 833-540-8648
McLarenHealthPlan.org/McLarenMedicare