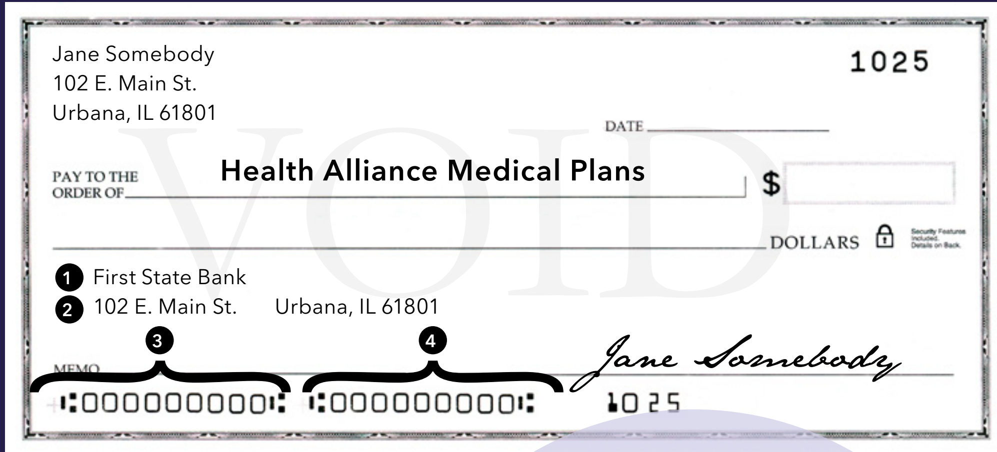
Automatic Premium Payment Program

Save time with this convenient, worry-free program made for you.

Health Alliance™ | 3310 Fields South Dr. • Champaign, IL 61822



Sample Voided Check

1. Name of financial institution.
2. Branch, city, state, ZIP.
3. Routing number.
4. Account number.

Two Options Made for You

1. Your Bank (checking or savings) – Fill out the bottom panel of this brochure and send it to us. Your payment will be pulled on the 10th of the month, or the nearest business day. For checking be sure to enclose a voided check.

2. Credit Card – Once you're enrolled, you'll be able to set up monthly payments at login.hally.com or through the Hally™ mobile app using your Visa, Mastercard or Discover credit card.

After completing the appropriate form, please mail it back to us in the envelope provided.

Enjoy the security of knowing your monthly plan premium is on time with our Automatic Premium Payment Program. It's an easy, dependable feature made to fit your needs.

1 Setting Up Monthly Credit Card Payments

Once you're enrolled, you'll be able to set up automatic monthly payments using your Visa, Mastercard or Discover credit card. Register or log in at login.hally.com or through the Hally™ mobile app to set up your payments. If you're a new member, watch for your welcome letter and member number in the mail. You'll need this to create your member account.

2 Setting Up Automatic Premium Withdrawal

How Automatic Payment Works

We'll deduct your plan premium from your bank account every month. If you have any questions, please call Member Services at (800) 965-4022 (TTY 711). Representatives are available from 8 a.m. to 8 p.m. weekdays. If the amount of your plan premium changes, we'll inform you at least 30 days in advance.

Email:
AutoDraw@HealthAlliance.org

Attn: Auto Pay
Health Alliance Medical Plans
3310 Fields South Dr.
Champaign, IL 61822

Fax:
(217) 902-9784

Name (First, Middle Initial, Last):	Financial Institution of Payor (See voided check sample on back for this information):	
Social Security Number:	Name:	Branch:
Phone Number:	City, State, ZIP:	
Make this deduction from: Checking (Enclosed voided check.) Savings	Routing Number:	Account Number:

I hereby authorize Health Alliance™ Medical Plans, Inc., and the financial institution named above to initiate monthly debit entries, on the appropriate date and in the amount of the current premium for my plan, and to initiate, if necessary, credit entries and adjustments for any debit entries in error to the account and financial institution indicated above. This authority is to remain in effect until Health Alliance has received written notification from me of its termination in such time as to afford Health Alliance and the financial institution a reasonable opportunity to act on it.

Signature   Date