AMERICAN MEDICAL SECURITY
Be for Good Health®
P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

Would you like to save time?

Time is a valuable asset, which should not be wasted. That's why American Medical Security, Inc., administrator of your insurance plan, would like to offer you the chance to have your monthly premiums automatically withdrawn from your checking account or charged to your credit card.

Save time. Forget the hassle of writing checks month after month, and trying to remember to mail the check before the due date. American Medical Security, Inc. will take care of it for you by withdrawing your monthly premium at the beginning of each month in which it is due.

Automatic withdrawal is efficient and easy. Start saving time today. Simply select your method of payment, complete that method's authorization section and drop it in the mail to American Medical Security, Inc., P.O. Box 19032, Green Bay, WI 54307-9032

If you have any questions, please call your account specialist listed on your billing statement or a customer service representative at (800) 232-5432.

Please fill in this section.

❑ New Application

❑ Change Checking Account Information

❑ Change from Standard Bill to Check-O-Matic

Applicant/Payer Name _____ Group No. _____

Please select the method of payment.

❑ Check-O-Matic Authorization

Attach a voided check here
All premiums will be withdrawn the first of the month.

Name of Depositor _____
(Print exact name as it appears on Financial Institution records)

Address _____ Phone No. ( ) _____

I (we) hereby authorize American Medical Security, Inc. to initiate debit entries to my (our) checking account and the Financial Institution named below to debit the same to such account. American Medical Security, Inc. will not be held responsible for a policy lapse or cancellation due to nonpayment if the withdrawal is presented and not honored for any reason and the amount due is not paid.

Financial Institution Name _____

Financial Institution Phone No. ( ) _____

Street Address _____

City _____ State _____ ZIP _____

This authority is to remain in full force and effective until American Medical Security, Inc. and the Financial Institution have received written notification from me (either of us) of its termination in such time and in such manner as to afford American Medical Security, Inc. and the Financial Institution a reasonable opportunity to act on it.

Name(s) _____

Date _____ Signature X _____

Note: If the VISA/MasterCard/Discover request for payment is declined, or the Check-O-Matic or direct payment by check transaction is returned for nonsufficient funds, a $25 nonrefundable service fee will be applied where allowed by state law.

❑ Credit Card Authorization

(Not available in Alabama; in North Carolina the credit card must be issued from a North Carolina bank)

❑ VISA ❑ MasterCard ❑ Discover

I authorize American Medical Security, Inc. to bill my VISA/MasterCard/Discover account for the premium (there will be an administration fee charged depending on the state).

Account Number					–					–					–					Exp. Date			/		

Signed at: _____ Signature: X _____
(City, State)

Phone No. ( ) _____