SINCE 1985

SENIOR DIMENSIONS®

a product of Health Plan of Nevada, Inc.SM

| Member name: | Member number (located on your member ID card): |
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**PREMIUM PAYMENT OPTIONS CHANGE FORM for Senior Dimensions (HMO)**

(You must select ***one*** of the premium payment options below. Generally, you must stay with the option you chose for the entire calendar year; you are generally not allowed to switch your payment options within the coverage year.)

| **Check one** | |
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| | Your plan premium for the Part D Prescription Drug Benefit is: $____________<br>People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.<br><br>If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.<br><br>Your *plan* premium for services covered under Medicare Part A & B is: $____________<br>(You must still continue to pay Medicare Part B premiums, and/or Part A premiums, if applicable.)<br>If you don't select a payment option you will get a bill each month. |
| ☐ | **Direct monthly payment by check or money order** |
| ☐ | **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**<br>The Social Security/RRB may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums. If you opt to change this option in the future, it can take two or more months to end.<br><br>Please call Customer Service if you are considering this payment option. You may call Customer Service October 1 through February 14: 8:00 a.m. to 8:00 p.m. local time, 7 days a week. Between February 15 through September 30: 8:00 a.m. to 8:00 p.m. local time, Monday through Friday at 702-242-7301 or 800-650-6232 (TTY/TDD 711). |
| ☐ | **Electronic Funds Transfer (EFT) from your bank account each month** (if you select this option, please complete the monthly bank draft authorization below)<br>Monthly Bank Draft Authorization<br>Bank name:<br>Type of account: ☐Checking ☐Savings — Account holder name (as it appears on bank records):<br>Bank Account number: — Bank Routing number:<br>I authorize Health Plan of Nevada, Inc. (HPN) to initiate debit entries to the account listed above at the bank or credit union (institution) listed above **equal to the monthly billed premium and/or any past due premiums.** This authorization is to remain in full force and effect until HPN and the institution have received written notification from me of its termination in such a manner as to afford HPN and the institution a reasonable opportunity to act on it. I have the right to stop payment of a debit entry by notification to the institution prior to charging the account. After the account has been charged, I have the right to have the amount of an erroneous debit credited to my account, provided I send written notice of the error to the institution within 15 days of the issuance of the account statement or |

| | 45 days after posting, whichever occurs first. Should this right be exercised, I will notify HPN prior to such action to make arrangements for continuation or termination of coverage. My premium will be debited on or after the 10th of every month.<br>1. Please enclose a **pre-printed voided check** from which monthly premiums are to be withdrawn.<br>2. In the event the monthly premium changes (after you have been notified), the new premium rate will be deducted from this account. |
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| **Please sign below.** (If you are requesting monthly bank draft, please sign your name as it is indicated on your bank records.) | |
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| Member signature: | Date: |
| If the account to be charged for premiums does not belong to the member, in addition to the signature of the member above, we need the signature account holder below. The account holder needs to sign their name as it is indicated on the bank's records. | |
| Account Holder Name as it appears on bank records (if not the member) | Date: |

To receive this information in a different format, please contact the plan.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.