Senior Care Plus
A Prescription Drug Plan from Hometown Health

2018 ElectronicFunds Transfer Form

Prescription Drug Plans

Member Name: _____ **Member Number:** _____

Please Select Your Option:

☐ Checking Account ☐ Savings Account

☐ Please **START** Electronic Funds Transfer from my account effective
(Attach your first month's premium.)

*I hereby authorize Senior Care Plus to deduct the amount selected above from my bank account by Electronic Funds Transfer (EFT) on or after the **5th** of each month, until my written notification of cancellation is received by Senior Care Plus.* Effective Date:

☐ Please **CHANGE** the Electronic Funds Transfer from my current account to my new account effective. (Attach a voided check below.)

I hereby authorize Senior Care Plus to cancel premium deductions from my bank account. Effective Date:

☐ *I qualify for Extra Assistance from (Nevada's Senior Rx Program) or Medicare/Medicaid. This means, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare does not cover. Selection of a plan is required, even if you have a reduction in premium. If we determined that you owe a late enrollment penalty, we will deduct the amount along with your premium payment*

RETURN COMPLETED FORM TO:
SENIOR CARE PLUS
10315 Professional Cir.
Reno, NV 89521
ATTN ENROLLMENT

Senior Care Plus must receive this form by the end of the month to be effective the 1st of the next month.

Signature:	**Date:**

OFFICE USE

Date:	**Bank Name:**	
Account #:	**Checking**	**Savings**
Routing #:	**Rep Name:**	