MEMORIAL HERMANN HEALTH SOLUTIONS, INC.
For itself and its affiliated companies: Memorial Hermann Health Plan, Inc., Memorial Hermann Health Insurance Company, Memorial Hermann Commercial Health Plan, Inc.

Memorial Hermann Health Plan, Inc.
Memorial Hermann Health Solutions, Inc.
Memorial Hermann Health Insurance Company
Memorial Hermann Commercial Health Plan, Inc.

Automated Clearing House (ACH) Authorization

If you are interested in setting up your account for auto draft payments or in making a one-time payment, please complete this form and return to the address below, along with a blank check marked "VOID":

Memorial Hermann Health Solutions, Inc.
Attn: Finance - Premiums Team
929 Gessner Road, Suite 1500
Houston, TX 77024

You can also fax to 713.338.6860 or email to member-premiums@memorialhermann.org.

I request and authorize Memorial Hermann Health Solutions, Inc. and/or its designee to obtain payment of amounts becoming due by initiating charges to my account; and I request and authorize the financial institution named below to accept and honor the same to my account. As the account holder, by signing below, I certify, in the event that this draft is being drawn from a company checking account, that I am authorized to approve this transaction. I understand that both the financial institution and Memorial Hermann Health Solutions, Inc. reserve the right to terminate this payment program and/or my participation therein.

I also understand that I may discontinue this payment program as of the first (1st) of any coverage month with 30 days advance notice using this form (see options below).

Application amounts or initial payments will be deducted as soon as possible. Please ensure your account is funded to cover the total amount due.

Group/Subgroup Number: ______________________________

Group Name: ______________________________

Group Address: ______________________________

Bank Name: ______________________________

Name on Account: ______________________________

Routing/Transit Number: ______________________________

Account Number: ______________________________

Payment Options:

- □ Initial Premium Payment (*approximate first month's premium*): $___________
- □ Recurring Monthly Premium Payment *(Drafts occur on the first (1st) of every coverage month.)*
- □ One Time Premium Payment: $___________ Month:_______________
- □ Discontinue all Premium Payments (30 days advance notice required)

I have read and accept the above agreement:

Authorized Signature: ______________________________

Authorized Printed Name: ______________________________

Date: ______________________________

Telephone Number: ______________________________

Check Example: