AULTCARE

Pay Your First QHP/Marketplace Monthly Premium

1. Log into your Marketplace account at https://www.healthcare.gov/login to begin the process.
2. Select "Continue."
3. Click your name in the top right and select "My Applications & Coverage."
4. Choose your application under "Your Existing Applications."
5. Click the blue button "Pay Your First Health Insurance Monthly Premium."
6. Online payment is available for your first payment. Choose the green button "Pay for Health Plan Now" to go to your insurance company's website to pay.

Make subsequent payments by choosing one of the following methods:

- Complete the Direct Withdrawal Authorization Form (next page) to set-up Electronic Fund Transfers from your bank account.
- Log into your AultCare member account at www.aultcare.com and select "Pay Now" to make secured electronic payments via bank account or debit/credit card.
- Call the AultCare automated payment line at 330-286-6066 to make secured payments over the phone via debit/credit card.
- Mail your physical payment and remittance voucher to the address on the bottom of your invoice.

If you have any questions, please contact AultCare at 330-363-6360 or 1-800-344-8858 (TTY: 711). Our hours of operation are Monday – Friday 7:30 am – 5:00 pm EST.

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Direct Withdrawal Authorization Form

Individual Insurance Premiums

I authorize AultCare Insurance Company to initiate an electronic draw of monthly premium deductions from my account listed below. This change is to be effective as of _____ (month/day/year). I understand I must maintain sufficient funds in my designated account to cover the total the Automated Clearing House (ACH) amount or my policy will lapse for non-payment of premium. This authorization will remain in effect until AultCare and my financial institution have received written notification of termination from me *(allow 7-10 business days for deductions to cease).*

Premiums are to be deducted from: ☐Checking ☐Savings (check one)
(Please note: Not all financial institutions allow deductions from a savings account. Please verify this with your financial institution.)

NAME OF FINANCIAL INSTITUTION | CITY | STATE

APPLICANT'S NAME (PLEASE PRINT) | PHONE NUMBER | MEMBER ID#

APPLICANT'S SIGNATURE | DATE

ACCOUNT HOLDER NAME (IF DIFFERENT FROM APPLICANT)

ACCOUNT HOLDER'S SIGNATURE | PHONE NUMBER | DATE

A voided check or voided check image is required when submitting this form. You may return this form via US Mail or electronically.

Physical forms with a **voided check** may be mailed to:

ATTN: BILLING
AultCare Insurance Company
P.O. Box 6910
Canton, Ohio 44706

Scanned/electronic forms with **voided check image** may be securely emailed to: AultCareBilling@aultcare.com