

## PAYMENT METHOD

**Member Name:**

**Contract number:**

(Refer to your Medical Plan Card)

**Coupon booklet**

You may make your payments at any Banco Popular de Puerto Rico branch, at our Service Centers, by calling Tele Pago at 1-866-627-8183 or online through [www.mcsclassicare.com](http://www.mcsclassicare.com).

Members with hearing impairments (TTY) may call at 1-866-627-8182. Our service hours are from Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31, and from Monday through Friday from 8:00 a.m. to 8:00 p.m., and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.

**Signature**  **Date**

**Discount from Social Security**  **Discount Railroad Retirement Board (RRB)**

**Activate**  **Cancel**

This discount may show in the Social Security or RRB check later (prospectively) and is processed in a period of approximately 45 days. You must make your payment until the discount appears in your Social Security or RRB check. If the Social Security Administration or RRB denies the discount request, your method of payment will be changed to a coupon booklet.

*Note: The payment method option does not apply to MCS Classicare Group health care coverage.*

**Signature**  **Date**

**Automatic discount**

You can choose one of the two available payment options. **Complete the following information.**

**Bank Account**

Type of Account:  **Savings**  **Checking**

**Account Number:**

**Route and transit Number (ABA):**

(please verify with your banking institution)

**Credit Card**

Card Type:  **Visa**  **Master Card**  **AMEX**

**Card Number:**

**Expiration Date:**

You hereby authorize MCS Advantage, Inc. to debit your bank account or credit card the monthly charges for the payment of the premium of the contract in reference. The automatic discount will be made on the 10th each month. To better identify your account, please submit a voided check (or a copy of this) of the account to be debited. In case of a savings account, please submit a copy of the identification that appears in the monthly statement.

Upon signing the request, I am agreeing to the terms and conditions mentioned above.

**Name (account owner):**

**Signature (account owner):**

**Member Signature**

**Date**

If you have any questions, contact the Finance Department at 787-758-2500 exts. 2738, and 2518. Send the completed document to: MCS Finance Department P.O. Box 193310 San Juan PR, 00919-3310; by email at [formulariodepago@medicalcardssystem.com](mailto:formulariodepago@medicalcardssystem.com) or fax at 787-622-2098.