健華人計保 CCHP Health Plan
445 Grant Ave., Suite 700, San Francisco, CA 94108
Tel: (415) 955-8800 • Fax: (415) 955-8817

CCHP use only
Finance: Entry date _____
Member Services or Sales: Recv'd date _____
DST entry date _____

Chinese Community Health Plan
Commercial Plans Automatic Bank Withdrawal Authorization Form
(Please complete all of the information in this form)

Member Information

Subscriber Name: _____
(as shown on your Member ID card)

Member ID: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email Address: _____

Financial Institution Information

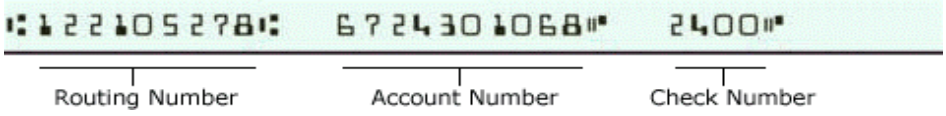
Name of Financial Institution: _____

Account Holder Name: _____ Account Type: □Checking □Savings

Bank Routing Number: _____ Bank Account Number: _____

Premium Amount: $_____ per month beginning _____

Please attach a voided check or deposit slip here.
We will use this information to withdraw your monthly plan premium from the account that you specify on the form.



NOTE: If you select automatic withdrawal as your payment option for your plan premium, you will receive monthly premium billing and **you do not need to send your payment to us**. The plan premium amount will be automatically withdrawn from the account. Your bank confirmation will be the prove of payment. If there are insufficient funds in the account or if the account is frozen/closed on the date of the withdrawal, you will be charged a $15 fee separately by CCHP.

Please Read and Sign Below

This agreement is between Chinese Community Health Plan ("CCHP") and the CCHP member for the automatic withdrawal of funds. The funds will be transferred on the 25th day of each month and will be used to pay monthly premium. If the 25th day of the month falls on a weekend or a holiday, the Automatic Payment will be debited from your account on the following business day. I understand I will resubmit a new form for automatic withdrawal if there is a change on my monthly premium amount.

I authorize Chinese Community Health Plan to instruct my financial institution to make plan premium payments from the account indicated above. I understand that if I decide to discontinue this method of payment at any time, I will notify CCHP in writing and make the plan premium payment using an alternative method.

Signature:_____ Date:_____

Please submit form by fax: 1-415-955-8817 or mail to CCHP, 445 Grant Ave, Suite 700, San Francisco, CA 94108 before the 20th of the month for changes to be effective the first day of the following month. If you have any questions or if you need help completing the form, please contact the CCHP Member Services Center at 1-888-775-7888 (TTY 1-877-681- 8898) from 8:00 a.m. to 8:00 p.m., seven days a week.

Other Payment Methods:

1. Pay online at CCHP website: http://cchphealthplan.com/how-to-pay

2. Pay in different ways at locations below:

Locations/Payment Methods	Pay in Person •Credit Card Online	Pay in Person •Credit Card	Pay in Person •Personal Check •Cashier's Check •Money Order	Pay by Mail •Personal Check •Cashier's Check •Money Order
Chinese Community Health Plan 445 Grant Avenue, #700, San Francisco, CA 94108	✓	✓	✓	✓
Member Services Center 845 Jackson Street, San Francisco, CA 94133	✓		✓	
Gellert Health Services 386 Gellert Boulevard, Daly City, CA 94015	✓			

3. Pay with Cash:
   Please bring the billing payment stub and pay by cash at:
   Bank of the Orient
   1023 Stockton Street, San Francisco, CA 94108