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
Medicare Advantage 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 : _____

Financial Institution Information

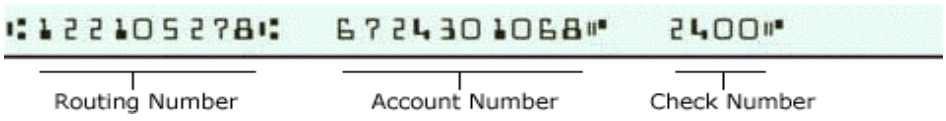
Name of Financial Institution: _____

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 The plan premium amount will be automatically withdrawn from the account.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 proof 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 between the 10th and the 15th day of each month and will be used to pay the plan premium.

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: 415-955-8817 or mail to CCHP, 445 Grant Ave, Suite 700, San Francisco, CA 94108 by 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:

Location/Payment Types	Credit Card Debit Card	Personal Check Cashier Check Money Order	Cash	Pay Online Walkthrough
Chinese Community Health Plan 445 Grant Ave, #700, San Francisco, CA 94108	o In person	o In person o By Mail		o In person
Member Services Center 445 Grant Ave, San Francisco, CA 94108		o In person		o In person
Gellert Health Services 386 Gellert Blvd, Daly City, CA 94015				o In person
Bank of the Orient 1023 Stockton St, San Francisco, CA 94108			o In person with Billing Payment Stub	
CCHP Website http://cchphealthplan.com/how-to-pay	o Electronic			