445 Grant Ave., 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:_____________

Auto withdrawn month beginning ___________________________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.

⑆122105278⑆ 6724301068⑈ 2400⑈

Routing Number — Account Number — Check Number

<u>NOTE:</u> 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 The premium amount will be automatically withdrawn from the account according to the "Total Amount Due" on the premium billing. 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 on or around the 25th day of each month and will be used to pay monthly premium. If the transferred 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 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 mail to CCHP, 445 Grant Ave, San Francisco, CA 94108 before the 10th 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., Monday to Friday.

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		○ By Mail		
Member Services Center 890 Jackson St, San Francisco, CA 94133	○ In person	○ In person		○ In person
Gellert Health Services 386 Gellert Blvd, Daly City, CA 94015	○ In person			○ In person
Bank of the Orient 1023 Stockton St, San Francisco, CA 94108			○ In person with Billing Payment Stub	
CCHP Website http://cchphealthplan.com/how-to-pay	○ Electronic			