



**CCHP**  
Health Plan

445 Grant Ave., San Francisco, CA 94108  
Tel: (415) 955-8800 • Fax: (415) 955-8817

**Internal 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.**

  
 Routing Number                      Account Number                      Check Number

**NOTE:** If you select automatic withdrawal as your payment option for your plan premium, you will not 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premium billing and **you do not need to send your payment to us.** The plan premium amount will be automatically withdrawn from the account.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 on or around the 15th day of each month and will be used to pay the plan 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 or mail to CCHP, 445 Grant Ave, San Francisco, CA 94108 by 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  
 October 1 - March 31 | 7 days a week 8:00 a.m. to 8:00 p.m.  
 April 1 - September 30 | Monday - Friday 8:00 a.m. to 8:00 p.m.

**Other Payment Methods:**

Location/Payment Types	Credit Card Debit Card	Personal Check Cashier Check Money Order	Cash	Pay Online Walkthrough
<b>CCHP</b> 445 Grant Ave. San Francisco, CA 94108		<input type="radio"/> By Mail		
<b>Member Services Center</b> 445 Grant Ave. San Francisco, CA 94108	<input type="radio"/> In person	<input type="radio"/> In person		<input type="radio"/> In person
<b>Gellert Health Services</b> 386 Gellert Blvd. Daly City, CA 94015	<input type="radio"/> In person			<input type="radio"/> In person
<b>Bank of the Orient</b> 1023 Stockton St. San Francisco, CA 94108			<input type="radio"/> In person with Billing Payment Stub	
<b>CCHP Website</b> <a href="http://www.cchphealthplan.com/how-to-pay">www.cchphealthplan.com/how-to-pay</a>	<input type="radio"/> Electronic			