Together with CCHP
PO Box 1997 - MS 6280 | Milwaukee, WI 53201-1997
Toll-free: 1-844-201-4672 | togetherCCHP.org

Automatic Payment Election Form

Please fill out this form if you wish to pay your monthly plan premium through automatic bill pay. Your premium bill will be paid automatically each month using the bank account or credit card you specify below.

Complete and sign this form and return it:
By Fax: 414-266-1611 | By Email to: CCHP-MemberSales@chw.org

Member Information

MEMBER NAME _____ MEMBER EMAIL _____ MEMBER ID NO. _____

MEMBER BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

Payment Option (select one option)

Please indicate the month in which you wish to start electronic deductions from your account: _____
Upon receipt of this form, your automatic payment deduction will begin with the month you have listed on this form. Children's Community Health Plan will deduct your monthly premium from your account on the first of each month there after.

Checking / Savings Account
Please submit a voided or photocopied check with this form. If the voided check does not include transit or account numbers, please provide this information and submit it with this form.

Bank or financial institution name _____

Checking Account Number _____ Routing Number _____

Type of account: ☐ Checking ☐ Savings

Credit card option

Type of card: ☐ Visa ☐ MasterCard ☐ Discover

Account No. _____ Exp. Date _____

Authorization

I hereby authorize Children's Community Health Plan, its affiliates, and subsidiaries to electronically deduct the monthly premium payment from my account named above. This agreement is to remain in effect until Children's Community Health Plan has received written and signed notification. Children's Community Health Plan and the banking institution will require a reasonable advance notice allowing opportunity to act on the request. If any deduction is not honored by your bank, the premium will be considered not paid. Children's Community Health Plan will ask you to pay the dishonored amount. Children's Community Health Plan has the right to discontinue electronic payment if one automatic deduction is not honored. If the agreement is discontinued, you must resubmit a new agreement to resume electronic payments. Children's Community Health Plan may revise the terms of this agreement at any time upon written notification. Complete the following information exactly as it appears on your banking or credit card account:

PRINTED NAME OF ACCOUNT HOLDER _____ SIGNATURE _____ DATE _____

Internal Reference: TOG Member Form – Automatic Payment Election Form (2019.0701)