



COMMUNITY HEALTH NETWORK of Washington™

Cascade Select

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COMMUNITY HEALTH PLAN of Washington™

### ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION FORM

Member Name (print): \_\_\_\_\_ Member ID#: \_\_\_\_\_

I hereby authorize Community Health Network of Washington (the plan), to deduct my monthly insurance premium payments from my account as indicated by me below:

**Please complete the information below**

Account holder name (print): \_\_\_\_\_

Bank routing number: \_\_\_\_\_ Bank account number: \_\_\_\_\_

Financial Institution Name (print): \_\_\_\_\_

Type:  Checking  Savings

Attach a "VOIDED" check that is to be used to make the EFT payments and mail it to the address below:

Community Health Network of Washington  
Attn: Finance Cascade Care  
1111 Third Ave, Suite 400  
Seattle, WA 98101

**When will the EFT start?**

We'll send you a notice with the EFT start date. Implementing your EFT request may take up to 30 days. Please continue to pay your premiums as you have been until EFT starts.

**When does payment draft?**

Payment will always draft on the 20<sup>th</sup> of every month, if the 20<sup>th</sup> falls on a weekend then the draft will be the next business day.

**Authorization Signature**

This authority is to remain in effect until the plan has received written notification from me of its termination in such time and in such manner as to afford the plan and the financial institution a reasonable opportunity to act on the request. If any deduction is not honored by my bank, my premium will be considered not paid. The plan will ask me to pay the dishonored amount, plus a \$20 fee for non-sufficient funds (NSF) on either returned checks or automatic payment deduction transactions. After timely payment is received by the plan, deductions will resume. The plan has the right to discontinue the Pre-Authorized Payment plan if any two or more deductions are not honored. The plan may notify me in advance whenever the deduction amount or deduction day changes. The plan may revise the terms of this agreement at any time upon written notification.

Signature of Member: \_\_\_\_\_ Date: \_\_\_\_\_