Affinity Health Plan
Dedicated to Excellence

CHILD HEALTH PLUS DIRECT PAYMENT AUTHORIZATION

-DEBIT-

☐ NEW ACCOUNT ☐ CHANGE IN ACCOUNT

BY MY SIGNATURE I AUTHORIZE AFFINITY HEALTH PLAN TO DEDUCT FROM MY CHECKING ACCOUNT THE AMOUNT OF $_____ ON THE 10TH OF THE MONTH, EACH MONTH TO PAY THE CHILD HEALTH PLUS PREMIUM FOR AS LONG AS I REMAIN IN THE PROGRAM OR UNTIL THERE IS A CHANGE TO MY POLICY.

We will apply any advance payment you may have already made before deducting from your account. We will automatically vary the deduction amount if your premiums or level of coverage change. If we vary the deduction amount, we will give you at least 14 days written notice. However other deductions may take place to offset any outstanding balance due to payment rejection by your bank.

If the payment deduction date falls on a weekend or a holiday, we will debit your account on the next business day.

- *ONE MONTH PREMIUM IS PAID IN ADVANCE TO ACTIVATE THE POLICY.*
- *ANY FINES FOR INSUFFICIENT FUNDS WILL BE CHARGED TO MY ACCOUNT.*

Name:_____

Name of Bank:_____ ☐ Checking ☐ Savings

Account No. _____ Routing No._____.
*[please attach a check with "**VOIDED**" written on the front]*

Address:

I agree to all terms stated herein and have provided this information accurately and completely. I understand I am subject to all rules and conditions of my bank and any applicable laws.

Signature: _____ Date:_____

Subscriber ID's:_____