Missouri Consolidated Health Care Plan
Automatic Withdrawal Authorization
Public Entity Account - Entity

Submit this form
☐ Online: Upload through myMCHCP
Fax: 800-834-5181
Mail: PO Box 104355
Jefferson City, MO 65110-4355

Revised 12/2021

Section 1: Subscriber Information

<table>
<thead>
<tr>
<th>Group:</th>
<th>Account:</th>
<th>Entity Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Primary Contact: ___________________________________________
Email Address: ___________________________________________

☐ I hereby request to pay my monthly health insurance premiums via electronic withdrawal. I hereby authorize MCHCP to electronically deduct monthly premium installments for payment of my group health insurance. I also authorize MCHCP to deduct all amounts owed by me to MCHCP and to initiate credit entries in the event of erroneous charges. I authorize the financial institution ("Bank") named below to accept and post these transactions to my account. I also authorize MCHCP to adjust said transactions to reflect any premium changes and coverage renewals.

Section 2: Bank Information

Bank Name: ___________________________________________
Bank Address: ___________________________________________

City: ___________________________ State: ___________________________ Zip Code: ___________________________

Account Type: ___________________________  ☐ Checking  ☐ Savings
Routing Number: ___________________________  Account Number: ___________________________

Example Check:

City: ___________________________  State: ___________________________  Zip Code: ___________________________
Routing Number: ___________________________  Account Number: ___________________________

Section 3: Conditions & Subscriber Authorization

1. The premiums shall be withdrawn on or about the fifth day of the month.
2. The privilege of making payments may be revoked by MCHCP and my eligibility put on hold and/or my coverage cancelled if an electronic draft is rejected. I hereby acknowledge that it is my responsibility to promptly notify MCHCP of any banking or account changes that affect this automatic draft plan.
3. If this authorization is cancelled, it does not release me from my obligation to pay MCHCP for insurance coverage.
4. I also hereby authorize and acknowledge that MCHCP reserves the right to draft via Electronic Funds Transfer all amounts owed by the subscriber.
5. This authorization may be cancelled by the subscriber at any time, provided a written notice is delivered to: Missouri Consolidated Health Care Plan - Attn: Fiscal Affairs; PO Box 104355, Jefferson City, MO 65110-4355 15 days prior to cancellation date. No refunds shall be given for partial months.
6. This authorization shall apply to me, the following Applicant/Subscriber.
7. This authorization shall remain in effect until I provide written notice to MCHCP requesting cancellation.

Attach a voided check (not a deposit slip) to this form.

Signature: ___________________________  Date (MM/DD/YYYY): ___________________________ / / 

MCHCP 832 Weathered Rock Court  Jefferson City, MO 65101  573-751-0771  800-487-0771 www.mchcp.org