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

PEA ACH

Revised 12/2021

Section 1: Entity Information

Group: **Account:** **Entity Name:**

Primary Contact: **Email Address**:

☐ I hereby request to pay the Entity's monthly health insurance premiums via electronic withdrawal. I hereby authorize MCHCP to electronically deduct monthly premium installments for payment of the Entity's group health insurance. I also authorize MCHCP to deduct all amounts owed by the Entity 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 the Entity's 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:

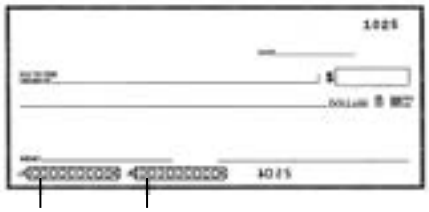
City: **State**: **Zip Code**:

Account Type:

☐ Checking ☐ Savings

Routing Number: **Account Number**:

Example Check:



Section 3: Conditions & Entity 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 The premiums shall be withdrawn on or about the fifth day of the month.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 the Entity's eligibility put on hold and/or its coverage cancelled if an electronic draft is rejected. **I here-by acknowledge that it is the Entity's 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 the Entity from its 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 Entity.
5. This authorization may be cancelled by the Entity 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 the following Applicant/Entity.
7. This authorization shall remain in effect until the Entity provides written notice to MCHCP requesting cancellation.

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

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