Missouri Consolidated Health Care Plan

Automatic Withdrawal Authorization

State Members

Submit this form
Online: Upload through myMCHCP
Fax: 866-346-8785
Mail: PO Box 104355
Jefferson City, MO 65110-4355

ST ACH

Revised 10/2021

Section 1: Subscriber Information

Name (Last, First, MI): ☐ New Name

_____ _____ _____

Email Address:

_____

OR

MCHCP ID:

_____ -

Social Security Number:

_____ - _____

☐ 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:

_____

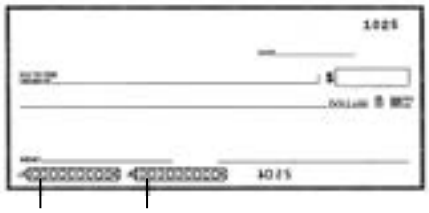
City: _____ **State**: _____ **Zip Code**: _____

Account Type:

☐ Checking ☐ Savings

Routing Number: _____ **Account Number**: _____

Example Check:



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 The premiums shall be withdrawn on or about the fifth day of the month.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): ____/____/____