Authorization agreement for automatic withdrawal

Complete this form to have premium payments automatically deducted from your checking or savings account. **Submit one form for each applicant.**

1. Banking Information:

Applicant/member name	Member ID	Account holder name
	G ___________	

Street address	Unit	City	State	ZIP code

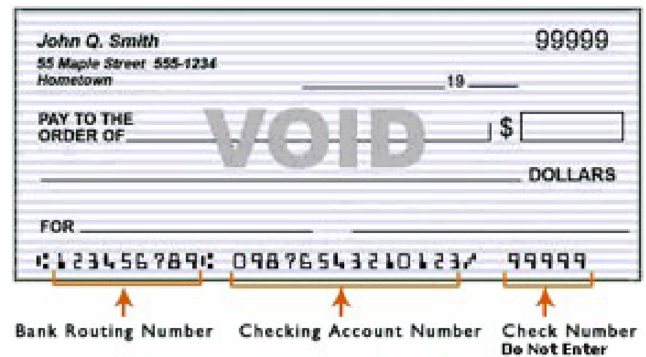
Bank name	Routing number	Account number

2. Please deduct the monthly premium from (check one of the following):

❑ Checking Account **(MUST attach voided check)**

❑ Savings Account **(MUST attach deposit slip)**

SAMPLE CHECK



3. Authorize withdrawal

I hereby authorize Aspire Health Plan to withdraw from the above checking/savings account the amount necessary to pay the premium for (applicant name) ___________________________. This authority will remain in effect until I notify Aspire Health Plan in writing to cancel, with enough time to allow the bank a reasonable opportunity to act on the cancellation. Furthermore, I certify that I am an authorized signer of this listed account according to the records of the financial institution listed above.

Please attach either a voided check for checking withdrawal or deposit slip for a savings withdrawal.

Name (please print) ____ Date____________________

Signature ____

If you have questions you should call us toll free at: (855) 570-1600 (TTY 711.) We are open 8 a.m.–8 p.m. PT Monday through Friday from April 1 through September 30 and 8 a.m.–8 p.m. PT seven days a week from October 1 through March 31 (except certain holidays).

Please mail this form to: Aspire Health Plan, PO Box 5490, Salem, OR 97304-0490

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