CCHP Health Plan

Direct Deposit/Ach Authorization Form

Complete the required information below to enroll, change, or cancel your current direct deposit at Chinese Community Health Plan.

The following documents must be attached to this form:

- Voided Check (Checking Accounts Only)
- Completed and signed W-9 Form. Vendor's business name must be identical to the bank account name and EIN/TIN. Please contact Tina Ho at 1-628-228-3283 with questions.
- Please submit form by email at brokers@cchphealthplan.com or mail to CCHP, 445 Grant Ave, Suite 700, San Francisco, CA 94108. Attn: Sales Department

I. Vendor's Information - (Please print legibly)

Vendor's Name

Employer/Tax Identification Number (EIN or TIN)

Business Name or DBA

Address

City

State

Zip Code

Phone Number

II. Direct Deposit Information

Circle one: New Change Cancel

Account Information:

Account Holder Name

Checking Account #

Bank/Financial Institution Name

Bank Routing #

Bank Address

City

State

Zip Code

III. Authorization

1. By signing this agreement, I authorize Chinese Community Health Plan (the Plan) to automatically deposit my claim payment into my account(s) each payday. The Plan reserves the right to recall or adjust any deposits improperly created and deposited to my account. I understand my direct deposit service may be suspended or rescinded by the Plan at any time.
2. It is my responsibility to notify the Plan of any account closures or changes. If the direct deposit is not stopped before closing an account, I agree to wait until the funds are returned to the Plan to receive my funds. This could take several weeks and will delay my payment.
3. I understand I may revoke my direct deposit authorization at any time by providing written notification to the Plan.
4. It is my responsibility to ensure that my claim payment is properly credited to my account before issuing any debits against my account. I will hold the Plan harmless for any liability to pay charges for insufficient fund transactions that result from failure within the Automated Clearing House Network to correctly and timely deposit monies into my account.
5. I agree to hold harmless and indemnify Chinese Community Health Plan and their employees, authorized personnel, from any claim or demand of whatever nature, including those based upon negligence, brought by any person, including any financial institution for failure or delay in making deposits and/or corrections to deposits as herein authorized. This authorization replaces any previously made by me and remains in effect until I cancel or submit a new authorization.

Signature: _____ Date: _____

Input by: _____ Date _____