ACHIA
ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

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AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize The ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION Plan to initiate debit entries to my checking account indicated below and the depository name below to debit the same to such account. The voided check must match the account number given on this form.

Member or Applicant Name_____
(PLEASE PRINT)

Member ID # (or Social Security #, if new applicant) _____

(MUST ATTACH A VOIDED CHECK)

Bank Name_____Branch_____

City _____ State_____ Zip_____

Routing /ABA NO._____ Account NO._____

This authority is to remain in full force and effect until The ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION Plan and DEPOSITORY has received written notification from me of its termination in such time to allow the ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION and DEPOSITORY a reasonable opportunity to act on it.

Date_____ Signed_____

Office Use Only

ACH Start Date_____ Change Date_____

ACH Amount _____Change Amt._____