COMMUNITY HEALTH PLAN of Washington™
MEDICARE ADVANTAGE

Payment Option Form

1111 3rd Ave, Ste 400, Seattle WA 98101 | Phone: 1-800-944-1247 (TTY Relay: 711) | Fax: 206-613-5089

Please contact us if you need information in another language or format (Braille).

Please Provide the Following Information

Member Name (print): _____ Member ID #: _____

I herby authorize Community Health Plan of Washington (the plan), to deduct my monthly insurance premium payments from my account as indicated by me below:

Paying Your Plan Premium

You may pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion or this premium, we will bill you for the amount that Medicare doesn't cover, If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ **Get a bill and pay by personal check on a monthly basis**.

☐ **Electronic Funds Transfer (EFT) from your bank account each month**
Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Account type: ☐ **Checking** ☐ **Savings**

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**
I get monthly benefits from: ☐ **Social Security** ☐ **RRB** (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

☐ **Pay online using your credit or debit card**. I will pay my monthly plan premium directly by using E-Bill Express, an online payment tool. Once I am a member, I will sign up on E-Bill Express to make single payments or set up automatic recurring payments from my credit or debit card. For more information or to enroll in this payment option, visit our website at: **medicare.chpw.org/member-center/member-self-service/pay-your-bills/**.

Signature

This authority is to remain in effect until the plan has received written notification from me of its termination in such time and in such manner as to afford the plan and the financial institution a reasonable opportunity to act on the request. If any deduction is not honored by my bank or by Social Security, my premium will be considered not paid. The plan will ask me to pay the dishonored amount, plus a $20 fee for non-sufficient funds (NSF) on either return checks or automatic payment deduction transactions. After timely payment is received by the plan, deductions will resume. The plan has the right to discontinue the Pre-Authorized Payment plan if any two or more deductions are not honored. The plan may notify me in advance whenever the deduction amount or deduction day changes. The plan may revise the terms or this agreement at many time upon written notification.

_____	_____
Signature of Member	Date