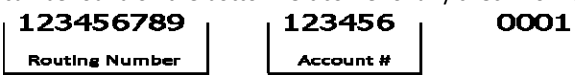
Colorado Choice Health Plans

☐ **Automatic Bank Draft Authorization (ACH)** ☐ **Debit Card** ☐ **Check (Use coupon below)**

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	M.I.	HOME PHONE		
SUBSCRIBER'S ADDRESS	APT NO		CITY	ST	ZIP
BILLING NAME (IF DIFFERENT)			BILLING PHONE # (IF DIFFERENT)		
BILLING ADDRESS (IF DIFFERENT)	APT NO		CITY	ST	ZIP
NAME OF BANK OF FINANCIAL INSTITUTION			CITY	ST	ZIP
Account Number (ACH or Debit)	Routing Number (ACH Only)	CVS Code (Debit Only)	Expiration Date on Debit Card		

*For an ACH this can be found on the bottom left corner of any check from the account to be used



I hereby authorize Colorado Choice Health Plans to debit the account shown above for my (the subscriber's) Colorado Choice Health Plans health coverage when my premium payment comes due. I authorize the bank or financial institution shown above to accept such debits without responsibility for their correctness. I may terminate this Automatic Bank Draft Authorization at any time by giving Colorado Choice Health Plans, or the bank or financial institution noted above, written notification of termination. I understand that such notification will become effective after Colorado Choice Health Plans, or the bank or financial institution noted above, has received the notification of termination and has had a reasonable amount of time to act upon it.

If the premium amount of my (the subscriber's) Colorado Choice Health Plans health coverage should change for any reason, Colorado Choice Health Plans will notify me in writing at least thirty (30) calendar days before the next premium is to be debited to the account.

Please Note there will be a $25 charge for each incident when an automatic draft or Debit Card is denied or returned for insufficient funds. This fee is in addition to any fees your financial institution may charge you.

BANK DRAFT EFFECTIVE MONTH (WITHDRAWAL WILL OCCUR ON OR AROUND THE 15th OF THE PRIOR MONTH)		
SUBSCRIBER'S SIGNATURE	ADDITIONAL SIGNATURE (IF ANY)	DATE

Account #
#########
Date Due
01/15/2016

Amount Due
$00.00

Date Paid

_____

Name
Address
City, ST Zip

Mail coupon with your check to:
Colorado Choice Health Plans
700 Main Street, Suite 100
Alamosa, CO 81101

Return This Coupon with Your Payment

Account #
#########
Date Due
01/15/2016
Amount Due
$00.00

Enter Amount Paid
$ _____

DO NOT SEND CASH