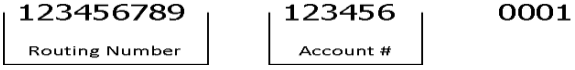
Colorado Choice Health Plans

☐ **Automatic Bank Draft Authorization (ACH)** ☐ **Debit Card**

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
NAME(S) SHOWN ON ACCOUNT TO BE DEBITED		ACCOUNT NUMBER TO BE DEBITED*		
SIGNATURE(S) SHOWN ON ACCOUNT TO BE DEBITED		ROUTING NUMBER*		
Expiration Date of Debit Card		CSV Code 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 you are enrolled through Connect for Health Colorado, this amount may change based upon information we receive from Connect for Health Colorado.

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