# Authorization agreement for automatic withdrawal

ASPIRE HEALTH PLAN

Complete this form to have premium payments automatically deducted from your checking or savings account. **Submit one form for each applicant.**

## 1. Banking Information:

| Applicant/member name | Member ID | Account holder name |
|---|---|---|
| | G _ _ _ _ _ _ _ _ _ _ | |

| Street address | Unit | City | State | ZIP code |
|---|---|---|---|---|
| | | | | |

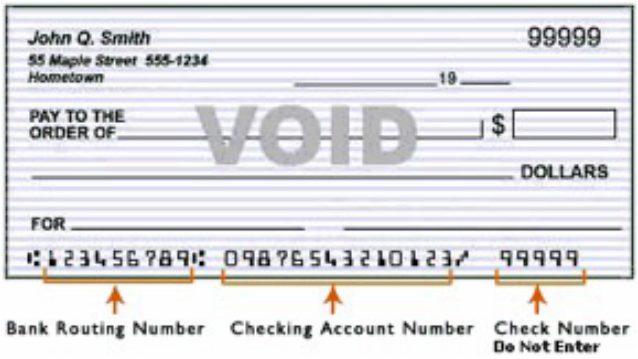
| Bank name | Routing number | Account number |
|---|---|---|
| | | |

## 2. Please deduct the monthly premium from (check one of the following):

❑ Checking Account
**(MUST attach voided check)**

❑ Savings Account
**(MUST attach deposit slip)**

SAMPLE CHECK




## 3. Authorize withdrawal

I hereby authorize Aspire Health Plan to withdraw from the above checking/savings account the amount necessary to pay the premium for (applicant name) _____. This authority will remain in effect until I notify Aspire Health Plan in writing to cancel, with enough time to allow the bank a reasonable opportunity to act on the cancellation. Furthermore, I certify that I am an authorized signer of this listed account according to the records of the financial institution listed above.

**Please attach either a voided check for checking withdrawal or deposit slip for a savings withdrawal.**

Name (please print) _____ Date_____

Signature _____

If you have questions you should call us toll free at: (855) 570-1600 (TTY 711.) We are open 8 a.m.–8 p.m. PT Monday through Friday from April 1 through September 30 and 8 a.m.–8 p.m. PT seven days a week from October 1 through March 31 (except certain holidays).

**Please mail this form to: Aspire Health Plan, 3993 Fairview Industrial Drive SE, Salem, OR 97302**