



**ACHIA**  
 A L A S K A  
 C O M P R E H E N S I V E  
 H E A L T H I N S U R A N C E  
 A S S O C I A T I O N

**ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION**

**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. _____