Chorus Community Health Plans

PO Box 1997 - MS 6280 | Milwaukee, WI 53201-1997
Toll-free: 1-844-201-4672 | chorushealthplans.org

Payment Election Form

Please fill out this form if you wish to pay your monthly premium through automatic payment deductions. You can also use this form to authorize us to deduct your first month's binder payment below. Your premium bill will be paid automatically each month using the payment information specified on this form.

Complete and sign this form and return it:
By Fax: 414-266-1611 | By Email to: CCHP-MemberSales@chorushealthplans.org

Member Information

MEMBER NAME _____ MEMBER EMAIL _____

MEMBER BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

Plan Information

Please select the plan type you are authorizing us to set up automatic payment deductions for and include the member ID #. If you are looking to set up automatic payment deductions for both a health plan and a dental plan, please note that two separate drafts will come out each month.

Plan Type: ☐ Health Plan ☐ Dental Plan

Health Plan ID No. _____ Dental Plan ID No. _____

Payment Information (select one option)

☐ Pay binder payment only

☐ Pay binder payment and set up automatic payment deductions

☐ Set up automatic payment deductions

By selecting to pay your binder payment above, you are authorizing Chorus Community Health Plans to deduct your first month's premium payment upon receipt of this form.

By selecting to set up automatic payment deductions above, you are authorizing Chorus Community Health Plans to begin deductions from your account on the first of each month after receipt of this form.

Bank or financial institution name _____

Checking Account Number _____ Routing Number _____

Type of account: ☐ Checking ☐ Savings

Account No. _____ Exp. Date _____

Credit card option

Type of card: ☐ Visa ☐ MasterCard ☐ Discover

Authorization

I hereby authorize Chorus Community Health Plans, its affiliates, and subsidiaries to deduct the monthly premium payment from my account named above. This agreement is to remain in effect until Chorus Community Health Plans has received written and signed notification. Chorus Community Health Plans and the banking institution will require a reasonable advance notice allowing opportunity to act on the request. If any deduction is not honored by your bank, the premium will be considered not paid. Chorus Community Health Plans will ask you to pay the dishonored amount. Chorus Community Health Plans has the right to discontinue payment if one automatic deduction is not honored. If the agreement is discontinued, you must resubmit a new agreement to resume electronic payments. Chorus Community Health Plans may revise the terms of this agreement at any time upon written notification. Complete the following information exactly as it appears on your banking or credit card account:

PRINTED NAME OF ACCOUNT HOLDER _____ SIGNATURE _____ DATE _____

Internal Reference: COR Member Form – Automatic Payment Election Form (2022.0928)