CENTRAL HEALTH PLAN OF CALIFORNIA

Authorization Agreement
Electronic Funds Transfer (EFT) Payment

This form must be completed and submitted to CHPC in order for a supplier to be set-up to receive EFT Credits.

I (we) hereby authorized **CENTRAL HEALTH PLAN OF CALIFORNIA, INC.**, hereinafter called COMPANY, to initiate credit entries to my (our) Checking account indicated below and the depository institution named below hereinafter called DEPOSITORY, to credit the same to such account.

This section is to be completed by the entity receiving payment

Entity Name	Social Security / Tax ID #		
Contact Name & Phone (Required if the entity receiving payment is an Organization)	Set-up Type (check one) ☐ New EFT Authorization ☐ Revision to Current Authorization (i.e. account or bank changes) ☐ EFT Termination Request		
Street Address	City	State	Zip Code
Contact Person Email Address (Optional)			
Bank Name			
Bank Contact Person	Bank Phone Number		
Account Title as Filed at Bank			
Bank Routing Number, 9-digits (Verify with Bank)			
Bank Account Number (Verify with Bank)			
Additional banking instructions, if applicable (Verify with Bank)			

You must attach a voided check or proof of the account, indicating account name and number.

This authority is to remain in effect until Company has received written notification from us of its termination is such time and such manner as to afford Company a reasonable opportunity to act on it. We recognize that changes to the banking information must be communicated immediately.

I have verified with my bank that all of the information above is complete and correct.

Authorized Signature: _____ **Date**:_____

Print Name & Title: _____
(Must be an authorized signer of the account listed above)

FOR CHPC FINANCE DEPARTMENT USE ONLY		
Date Received:	Effective Date:	Vendor Name:
Please allow 15 business days for enrollment process completion.		