CHAND
Comprehensive Health Association of North Dakota

AUTOMATIC PAYMENT WITHDRAWAL

Name: _____ Address: _____

Benefit Plan Number: _____ Requested Effective Date: _____

Name of Financial Institution:_____

Address of Financial Institution: _____

ABA (bank routing) Number: _____

Account Number: _____ checking ❒ savings ❒

Is this a business account: yes ❒ no ❒

I hereby authorize my Financial Institution to deduct the current premium from my checking or savings account and remit the same to CHAND. This authorization is to continue in effect until revoked by me in writing. I understand a 30-day notice is needed when canceling an automatic withdrawal authorization. CHAND is not responsible for overdrafts and fees due to insufficient funds in my account.

Date: _____ Signature: _____

Please attach a voided check and mail to:
Comprehensive Health Association of North Dakota
4510 13th Avenue South Fargo, ND 58121