SHARP HEALTH PLAN

Sharp Health Plan Medicare
Bank Withdrawal Pre-Authorization Form

Name of Account Holder:	

Name of Member (If different than Account Holder):	Sharp Health Plan ID Number:

Bank Name:	Account Type: ☐ Checking ☐ Savings

Bank Address:	City:	State:	Zip Code:

Bank Draft* Date: Your draft* will occur on the 3rd of the month.
If the 3rd of the month falls on a weekend or bank holiday, your draft* will occur on the next banking day.

For Savings Accounts Only:

Bank Routing #:	Account #:

For Checking Accounts, please attach blank, voided check below.

I hereby authorize the bank or financial organization named above to pay my plan premium through monthly check or electronic account debits drawn by and payable to Sharp Health Plan.
Please note that it can take up to 90 days for the bank withdrawal to take effect. You will continue to receive a bill in the mail even after bank withdrawal begins.

Your Signature Account Holder, please sign as signature appears on signature card at bank **x**	Date:

Please tape (do not staple) a blank, voided check in this space
that you would like your premium payment deducted from.

Please return to:
Sharp Health Plan
Enrollment Dept.
8520 Tech Way, Suite 201
San Diego, CA 92123

Questions?
We're here to help.
Call us at 1-855-562-8853 (TTY/TDD: 711).

*A bank draft is a payment on behalf of a payer
that is guaranteed by the issuing bank.

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