Bank Withdrawal Pre-Authorization Form

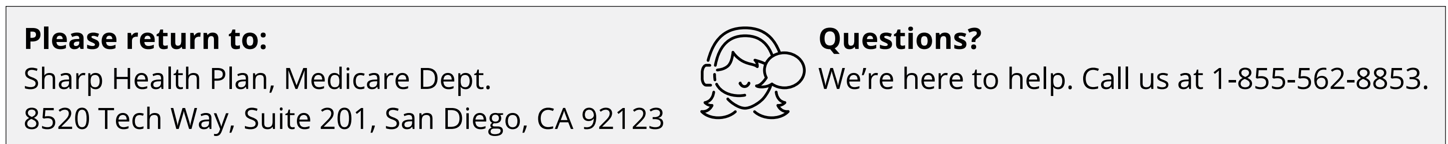
Member Information			
Name of Account Holder:			
Name of Member (If different than Account Holder):	ID Number:		
Bank Name:	Account Type: ☐ Checking ☐ Savings		
Bank Address:	City:	State:	Zip Code:

Bank Draft Date: Your draft will occur on the 3rd of the month. If the 1st of the month falls on a weekend or bank holiday, your draft will occur on the next banking day. A bank draft is a payment on behalf of a payer that is guaranteed by the issuing bank.

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 pre-authorization to take effect.	
Your Signature*:	Date:

*(Account Holder, please sign as signature appears on signature card at bank).

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, Medicare Dept.
8520 Tech Way, Suite 201, San Diego, CA 92123

Questions?
We're here to help. Call us at 1-855-562-8853.

H5386 2022 ACH Form_C