CAGW HEALTHCARE PROGRAM

UPDATE CONTACT/ PAYMENT METHOD INFORMATION

MEMBER

Last Name	First Name	Middle Initial

Group

Check all that apply.

- ☐ I am updating my contact information.
- ☐ I am updating my payment information.
- ☐ I am changing my payment method.

CONTACT INFORMATION

Billing Address			Work/ Day Telephone Number
City	**State**	**Zip**	**Home / Evening Telephone Number**
Email			**Fax Number**

PAYMENT INFORMATION

CHOOSE A PAYMENT FREQUENCY ☐ **MONTHLY** ☐ **QUARTERLY** ☐ **BI-ANNUALLY** ☐ **ANNUALLY**

☐ **CHECK**

Be sure to include a check with the correct premium amount.

☐ **CREDIT CARD**

(Visa/ MasterCard/ American Express)

Card Number

Exp. Date

Name on Card

☐ **DIRECT DEBIT**

Account Number

Routing Number

The Routing Number is located to the left of the Account Number.

Be sure to enclose a payment for your current premium amount due.
Automatic payments begin on your next bill.

Until further written notice, your signature authorizes the Cultural Alliance of Greater Washington, its successors or assigns to debit your checking/ savings/ charge account for payment, as directed above, on or about the payment due date of the 15th of the month for your health insurance premiums due.

Signature_____ **Date**_____

You may fax this form to: **Fax: 202-638-3388** **Attn: Health Care**

You may mail this form to:
Cultural Alliance of Greater Washington
Attn: Health Care
1436 U Street, NW, Suite 103, Washington, DC 20009