

# C AND O EMPLOYEES' HOSPITAL ASSOCIATION

511 MAIN STREET, 2nd FLOOR  
CLIFTON FORGE, VIRGINIA 24422-1166  
TELEPHONE (540) 862-5728/5729 (800) 679-9135 FAX (540) 862-3552/4958

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## METHOD OF PAYMENT FORM

Choose One:

\_\_\_\_\_ I wish to pay directly to the Association either quarterly, semi-annually or annually. Circle one and fill in your social security number and signature at the bottom.

\_\_\_\_\_ I wish to participate in the automatic dues deduction program. I have completed the following information and have included a voided check to verify this information.

I, \_\_\_\_\_ (please print), do hereby authorize the C and O Employees Hospital Association to initiate direct deduction from my checking account for my monthly dues premium for health insurance. I understand that my premium deduction may increase and that I may cancel the automatic deduction at any time. I understand this premium will be deducted the 5<sup>th</sup> of each month. The current monthly rate is \$ \_\_\_\_\_.

\_\_\_\_\_ Name of Bank  
\_\_\_\_\_ Street Address of Bank  
\_\_\_\_\_ City and State of Bank  
\_\_\_\_\_ Phone Number of Bank  
\_\_\_\_\_ Checking Account Number  
\_\_\_\_\_ Routing Transit Number (first 9 digits located on check)  
\_\_\_\_\_ Your Social Security Number  
\_\_\_\_\_ Signature