

CheckEase Direct Giving Change Request Form



Christian Healthcare Ministries *Galatians 6:2, Acts 2 & 4*

Name: _____ CHM #: _____

Daytime phone #: _____ Date: _____

I would like this change effective for my _____ gift.
(month/year)

PLEASE GIVE AT LEAST 10 DAYS NOTICE FOR THIS CHANGE TO BE PROCESSED ON TIME.

Choose all that apply:

I would like to change the account from which my monthly gift is withdrawn.

(Financial institution name)

(Branch)

(Address)

(City, state, zip)

(Routing number)

(Account number)

Checking account

or

Savings account

PLEASE ATTACH COPY OF VOIDED CHECK (if choosing checking account) OR DEPOSIT SLIP (if choosing savings account).

I would like to make an additional monthly contribution to the Prayer Page: \$ _____

I would like to change my monthly gift amount from \$ _____ to \$ _____

I would like to change my CheckEase debit date from _____ to _____

Please end my participation in CheckEase Direct Giving effective with my
_____ gift.
(month/year)

Signature: _____

YOU WILL RECEIVE A LETTER CONFIRMING THE EFFECTIVE DATE OF THE CHANGE(S).

Return form to: Christian Healthcare Ministries
Attn: CheckEase Direct Giving

127 Hazelwood Ave.
Barberton, OH 44203

Questions?
330-798-6555 or 800-791-6225, ext. 6555
330-798-5234 fax • swhite@chministries.org
www.chministries.org