

# CheckEase Direct Giving Change Request Form

Web version



Christian Healthcare Ministries

*Galatians 6:2, Acts 2 & 4*

Name: \_\_\_\_\_ CHM member #: \_\_\_\_\_

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I would like to change the account from which my monthly gift is withdrawn.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) FROM THE NEW ACCOUNT.**

I would like to add an additional gift amount of: \$ \_\_\_\_\_

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

PO Box 29  
127 Hazelwood Ave.  
Barberton, OH 44203

Questions?  
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