AUTHORIZATION REVOKED (PAYOR)

I hereby authorize Kansas Farm Bureau Health Plans to cancel debit entries to the account identified below for the monthly payment on the health or dental coverage set forth below. I acknowledge that I am signing this agreement on behalf of all covered individuals, and signatories to the account, and am authorized to do so.

I understand that I am not the member and thus not authorized to cancel coverage on behalf of the member. The member will be given notice in writing as to the continuance of their coverage.

As Payor for the health or dental coverage stated below, I hereby agree to these terms and conditions.

Health ____ Dental ____

Applicant/Member Name ______________________________

Applicant/Member Identification # ______________________

___________________________ ___________________________
Payor Bank Routing Number Payor Account Number

___________________________ ___________________________
Signature of Payor (Required) Print Payor Name (Required)

____
Date