

Medicare Supplement Bank Draft Authorization Form

General Information

- All requested information below is required to authorize your automatic bank draft.
- Upon completion, please submit to address, fax or email above.
- For bank changes, the form must be received 10 days prior to the draft date in order to be effective for the next draft.
- Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.
- **Cancellation-** the Subscriber may cancel this coverage for any reason by giving ten (10) days written notice to Kansas Farm Bureau Health Plans. Coverage will remain in effect until the paid-to-date. See your contract for specific information regarding cancellations and cancellations due to death of Subscriber.

Applicant/Subscriber Information

| | | |
|----------------------------------|----|----------------------------------|
| First Name | MI | Last Name |
| Health Plan Subscriber ID Number | | Dental Plan Subscriber ID Number |

Banking Information Please complete or attach voided check.

| | | | |
|---------------------|------------------|---------------------|--|
| Authorization Type: | New Applicant | Existing Subscriber | Requested Date of Change (for existing Subscribers) |
| Account Type: | Checking Account | Savings Account | |

Check this box if the **Primary Name on Bank Account** is not the same as the **Primary Applicant** for coverage. This serves as authorization for payments to be made from the bank account entered below.

| | |
|----------------------------------|----------------|
| Name of Financial Institution | |
| Address of Financial Institution | |
| Routing Number | Account Number |

Authorization

I hereby authorize Kansas Farm Bureau Health Plans to initiate debit entries from the account indicated above for the monthly payment of health coverage. The depository named above is authorized to debit my account. I acknowledge I am authorized to sign this agreement on behalf of all covered individuals and signatories to the account. I understand I have the right to revoke this authorization by notifying Kansas Farm Bureau Health Plans in writing at least 10 days prior to the next draft date. I further agree that should a debit be dishonored, whether with or without a cause and whether intentionally or inadvertently, Kansas Farm Bureau Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

| | |
|-----------------------------------|--------------------|
| Applicant/Subscriber Printed Name | Payor Printed Name |
| Applicant/Subscriber Signature | Payor Signature |
| Today's Date | Today's Date |

A scanned, imaged, or photocopied version of this completely executed form will have the same force and effect as the original document.