KANSAS FARM BUREAU® Health Plans

# Bank Draft Authorization Form

Kansas Farm Bureau Health Plans
PO Box 1424
Columbia, TN 38402-1424
Phone: 833-282-5928
Billing Fax: 931-560-4278
billingmfp@fbhealthplans.com

## County Office or KFBHP Agent Use Only

| Subgroup | County | Branch |
|---|---|---|
| | | |

## 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 by the 20th of the month to be effective the first of the following month.
- 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 |
|---|---|---|
| | | |

| Requested Date of Change | Health Plan Subscriber ID Number | Dental Plan Subscriber ID Number |
|---|---|---|
| | | |

## Banking Information

| Authorization Type<br>☐ New Applicant ☐ Existing Subscriber | Requested Date of Change (for existing Subscribers) |
|---|---|
| | |

Please complete or attach voided check.

Account Type: ☐ Checking Account ☐ Savings Account

| 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 and/or dental 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 ten (10) days prior to the time payment is due. 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**<br>**(Must be completed and in the name of parent, step-parent or legal guardian of minor applicant)** | | **Payor Printed Name** | |
|---|---|---|---|
| **Applicant/Subscriber Signature** | **Today's Date** | **Payor Signature** | **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.***