



# Bank Draft Authorization Form

Farm Bureau Health Plans  
 PO Box 313  
 Columbia, TN 38402-0313  
 Phone: 877-874-8323  
 Billing Fax: 931-560-4278  
[billingmfp@fbhealthplans.com](mailto:billingmfp@fbhealthplans.com)

County Office or FBHP Agent Use Only		
Subgroup	County	Branch

General Information
<ul style="list-style-type: none"> <li>All requested information below is required to authorize your automatic bank draft.</li> <li>Upon completion, please submit to address, fax or email above.</li> <li>For bank changes, the form must be received at FBHP by the 20<sup>th</sup> of the month to be effective the first of the following month.</li> <li>Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.</li> <li><b>Cancellation-</b> the Subscriber may cancel this coverage for any reason by giving ten (10) days written notice to 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.</li> </ul>

Applicant/Subscriber Information						
<table border="1"> <tr> <td>First Name</td> <td>MI</td> <td>Last Name</td> </tr> <tr> <td>Requested Date of Change</td> <td>Health Plan Subscriber ID Number</td> <td>Dental Plan Subscriber ID Number</td> </tr> </table>	First Name	MI	Last Name	Requested Date of Change	Health Plan Subscriber ID Number	Dental Plan Subscriber ID Number
First Name	MI	Last Name				
Requested Date of Change	Health Plan Subscriber ID Number	Dental Plan Subscriber ID Number				

Banking Information												
<table border="1"> <tr> <td>           Authorization Type  <input type="checkbox"/> New Applicant   <input type="checkbox"/> Existing Subscriber         </td> <td>Requested Date of Change (for existing Subscribers)</td> </tr> <tr> <td colspan="2">Please complete or attach voided check.</td> </tr> <tr> <td colspan="2">Account Type: <input type="checkbox"/> Checking Account   <input type="checkbox"/> Savings Account</td> </tr> <tr> <td colspan="2">Name of Financial Institution</td> </tr> <tr> <td colspan="2">Address of Financial Institution</td> </tr> <tr> <td>Routing Number</td> <td>Account Number</td> </tr> </table>	Authorization Type <input type="checkbox"/> New Applicant <input type="checkbox"/> Existing Subscriber	Requested Date of Change (for existing Subscribers)	Please complete or attach voided check.		Account Type: <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account		Name of Financial Institution		Address of Financial Institution		Routing Number	Account Number
Authorization Type <input type="checkbox"/> New Applicant <input type="checkbox"/> Existing Subscriber	Requested Date of Change (for existing Subscribers)											
Please complete or attach voided check.												
Account Type: <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account												
Name of Financial Institution												
Address of Financial Institution												
Routing Number	Account Number											

Authorization						
<p>I hereby authorize Farm Bureau Health Plans to initiate debit entries from the account indicated below for the monthly payment of health and/or dental coverage. The depository named below 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 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, Farm Bureau Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.</p>						
<table border="1"> <tr> <td>           Applicant/Subscriber Printed Name            (Must be completed and in the name of parent, step-parent or legal guardian of minor applicant)         </td> <td>Payor Printed Name</td> </tr> <tr> <td>           Applicant/Subscriber Signature         </td> <td>Payor Signature</td> </tr> <tr> <td>           Today's Date         </td> <td>Today's Date</td> </tr> </table>	Applicant/Subscriber Printed Name (Must be completed and in the name of parent, step-parent or legal guardian of minor applicant)	Payor Printed Name	Applicant/Subscriber Signature	Payor Signature	Today's Date	Today's Date
Applicant/Subscriber Printed Name (Must be completed and in the name of parent, step-parent or legal guardian of minor applicant)	Payor Printed Name					
Applicant/Subscriber Signature	Payor Signature					
Today's Date	Today's Date					
<p><i>A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.</i></p>						