



## Bank Withdrawal Pre-Authorization Form

Name of Account Holder \_\_\_\_\_  
*(Please print)*

Name of Member \_\_\_\_\_ ID Number \_\_\_\_\_  
*(If different than Account Holder)*

Bank Name \_\_\_\_\_ Bank Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Account Type: *(check one)*    Checking    Savings

**Bank Draft Date:** Your draft will occur on the 1<sup>st</sup> of the month. If the 1<sup>st</sup> of the month falls on a weekend or bank holiday, your draft will occur on the next banking day.

For Savings Accounts Only: *(For Checking Accounts, please attach a blank, voided check below)*

Bank Routing #: \_\_\_\_\_ Account #: \_\_\_\_\_

I hereby authorize the bank or financial organization named above to pay my plan premium through monthly check or electronic account debits drawn by and payable to Farm Bureau Health Plans (the Company). I understand and agree that, if any payment authorized hereby is denied, the Company will contact me to make arrangements for an alternate form of payment, and that, if I provide, verbally or in writing, corrected information for the account, this authorization includes full authority for the Company to charge the account using such corrected information.

X \_\_\_\_\_ Date \_\_\_\_\_  
*(Account holder, please sign as signature appears on signature card at bank)*

*Please tape (do not staple) a blank, voided check in the space that you would like your premium payment deducted from.*

**Please return this form to:** P.O. Box 266380, Weston, FL 33326 or **Fax** to 800-784-1580