Farm Bureau Health Plans
PO Box 313
Columbia, TN 38402-0313
Phone: 877-874-8323
Billing Fax: 931-560-4278
Billingforms@fbhp.com

Bank Draft Authorization Form
For Under 65 and Dental Plans Only

County Office or FBHP 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 10 days prior to the draft date in order to be effective for the next draft.
- **Cancellation**- 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.

Applicant/Subscriber Information

First Name	MI	Last Name

Health Plan Subscriber ID Number	Dental Plan Subscriber ID Number

Banking Information

Authorization Type	Requested Date of Change (for existing Subscribers)
☐ New Applicant ☐ Existing Subscriber	

Please complete or attach voided check. 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 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 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.

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	**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.