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

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 at FBHP 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 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 ☐ 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 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.

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.