



Bank Draft Authorization Form

****For Under 65 and Dental Plans Only****

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

County Office or FBHP Agent Use Only		
Subgroup	County	Branch

General Information
<ul style="list-style-type: none"> 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. 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						
<table border="1"> <tr> <td>First Name</td> <td>MI</td> <td>Last Name</td> </tr> <tr> <td colspan="2">Health Plan Subscriber ID Number</td> <td>Dental Plan Subscriber ID Number</td> </tr> </table>	First Name	MI	Last Name	Health Plan Subscriber ID Number		Dental Plan Subscriber ID Number
First Name	MI	Last Name				
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. 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 Today's Date </td> <td> Payor Signature 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 Today's Date	Payor Signature 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 Today's Date	Payor Signature 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>				