



## Bank Draft Authorization Form

### 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 Texas 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 <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	
Check this box if the <b>Primary Name on Bank Account</b> is not the same as the <b>Primary Applicant</b> 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 Texas 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 Texas 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, Texas Farm Bureau Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

<b>Applicant/Subscriber Printed Name</b> (Must be completed and in the name of parent, step-parent or legal guardian of minor applicant)	<b>Payor Printed Name</b>
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Applicant/Subscriber Signature	Today's Date	Payor Signature	Today's Date
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*A scanned, imaged, or photocopied version of this completely executed form will have the same force and effect as the original document.*