Members Health Insurance Company

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 1st of the month. If the 1st 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 Members Health Insurance Company (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>