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


Members
HEALTH
INSURANCE