

Bank Withdrawal Pre-Authorization Form

For Savings Accounts Only: (For Checking Accounts, please attach a blank, voided checkbelow) Bank Routing #: Account #: I hereby authorize the bank or financial organization named above to pay my plan premisthrough monthly check or electronic account debits drawn by and payable to <members company="" insurance=""> (the Company). I understand and agree that, if any payment authorhereby is denied, the Company will contact me to make arrangements for an alternate for payment, and that, if I provide, verbally or in writing, corrected information for the account authorization includes full authority for the Company to charge the account using such conformation. X Date</members>	Name of Account Holde	•
Bank Name State State State Account Type: (check one)		(Please print)
Bank Name State Account Type: (check one)	Name of Member	ID Number
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 is 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 #:	(If a	fferent than Account Holder)
Bank Draft Date: Your draft will occur on the 1st of the month. If the 1st of the month is 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 #:	Bank Name	Bank Address
Bank Draft Date: Your draft will occur on the 1st of the month. If the 1st of the month is 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 #: Thereby authorize the bank or financial organization named above to pay my plan premisthrough monthly check or electronic account debits drawn by and payable to <members (insurance="" company=""> (the Company). I understand and agree that, if any payment author hereby is denied, the Company will contact me to make arrangements for an alternate for payment, and that, if I provide, verbally or in writing, corrected information for the account using such contact information. X Date</members>	City	State
Please tape (do not staple) a blank, voided check in the space that you would like	Account Type: (check of	e) Checking Savings
Bank Routing #: Account #:		
Bank Routing #:	=	y: (For Checking Accounts, please attach a blank, voided check
through monthly check or electronic account debits drawn by and payable to <members company="" insurance=""> (the Company). I understand and agree that, if any payment authority is denied, the Company will contact me to make arrangements for an alternate for payment, and that, if I provide, verbally or in writing, corrected information for the account authorization includes full authority for the Company to charge the account using such conformation. X</members>		Account #:
X Date	through monthly check of Insurance Company> (the hereby is denied, the Corpayment, and that, if I production includes further than the content of the conten	electronic account debits drawn by and payable to <members account,="" agree="" alternate="" an="" and="" any="" arrangements="" authorized="" company).="" contact="" corrected="" for="" form="" health="" i="" if="" in="" information="" make="" me="" of="" or="" pany="" payment="" td="" that,="" the="" thi<="" to="" understand="" verbally="" vide,="" will="" writing,=""></members>
(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	X	Date
Please tape (do not staple) a blank, voided check in the space that you would like		
		se tape (do not staple) a blank, voided
1		

Please return this form to: P.O. Box 266380, Weston, FL 33326 or **Fax** to (800) 784-1580

Members Health Insurance Company is a Part D plan with a Medicare contract. Enrollment in Members Health Insurance Company depends on contract renewal.



Members Health Insurance Company is a Part D plan with a Medicare contract. Enrollment in Members Health Insurance Company depends on contract renewal.