

Bank Draft Authorization Form

County Office or KSFHP Agent Use Only

Subgroup	County	Branch
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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 by the 20th of the month to be effective the first of the following month.
- Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.
- **Cancellation**- the Subscriber may cancel this coverage for any reason by giving ten (10) days written notice to Kansas 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
Requested Date of Change	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	
Name of Financial Institution	
Address of Financial Institution	
Routing Number	Account Number

Authorization

I hereby authorize Kansas 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 Kansas 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, Kansas Farm Bureau Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

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	Payor Signature
Today's Date	Today's Date

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.