Farm Bureau Health Plans
PO Box 313
Columbia, TN 38402-0313
Phone: 877-874-8323
Billing Fax: 931-560-4278
billingforms@fbhealthplans.com

Bank Draft Authorization Form

For Medicare Supplement Members Only

County Office or FBHP Agent Use Only

Subgroup General	County	Branch

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 at FBHP 10 days prior to the draft effective date.
- 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 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		Requested Date of Change (for existing subscribers)

Banking Information Please complete or attach voided check.

Authorization Type: ☐ New Applicant ☐ Existing Subscriber	Requested Monthly Draft Date ☐ 1st of each month ☐ 15th of each month
Account Type: ☐ Checking Account ☐ Savings Account	

☐ Check this box if the ***Primary Name on Bank Account*** is not the same as the ***Primary Applicant*** 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 Farm Bureau Health Plans to initiate debit entries from the account indicated above for the monthly payment of health 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 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, Farm Bureau Health Plans shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

Applicant/Subscriber Printed Name		**Payor Printed Name**	
Applicant/Subscriber Signature	**Today's Date**	**Payor Signature**	**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.