North Dakota Farm Bureau Health Plans
PO Box 1424
Columbia, TN 38402-1424
Phone: 866-544-1664
Billing Fax: 931-560-4278
Billingforms@fbhp.com

Bank Draft Authorization Form

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 10 days prior to the draft date in order to be effective for the next draft.
- **Cancellation**- the Subscriber may cancel this coverage for any reason by giving ten (10) days written notice to North Dakota 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	Dental Plan Subscriber ID Number

Banking Information

Authorization Type New Applicant Existing Subscriber	Requested Date of Change (for existing Subscribers)

Please complete or attach voided check.
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 North Dakota 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 North Dakota 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, North Dakota 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 **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.