Indiana Farm Bureau®
Health Plans
Insured by Members Health Insurance Company

Indiana Farm Bureau Health Plans
PO Box 1424
Columbia, TN 38402-1424
Phone: 888-964-0854
Billing Fax: 931-560-4278
billingforms@fbhpservices.com

Medicare Supplement 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.
- 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 Indiana 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 Monthly Draft Date	Health Plan Subscriber ID Number
☐ 1st of each month ☐ 15th of each month	

Banking Information

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

Please complete or attach voided check.

Account Type: ☐ Checking Account ☐ Savings Account

Name of Financial Institution

Address of Financial Institution

Routing Number	Account Number

Authorization

I hereby authorize Indiana 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 Indiana Farm Bureau Health Plans in writing at least 10 days prior to the next draft date. I further agree that should a debit be dishonored, whether with or without a cause and whether intentionally or inadvertently, Indiana 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.