

KANSAS HEALTH INSURANCE ASSOCIATION

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize The Kansas Health Insurance Association Plan to initiate debit entries to my checking account indicated below and the depository name below to debit the same to such account. The voided check **must match the account number given on this form**. Debits will be on the 5th of every month unless it falls on a holiday or weekend then it will be the next business day.

INSURED'S NAMES _____ INSURED'S SS# _____
(PLEASE PRINT)

(ATTACH A VOIDED CHECK)

DEPOSITORY
NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

TRANSIT/ABA NO. _____ ACCOUNT NO. _____

This authority is to remain in full force and effect until The Kansas Health Insurance Association Plan and DEPOSITORY has received written notification from me of its termination in such time to allow THE KANSAS HEALTH INSURANCE ASSOCIATION and DEPOSITORY a reasonable opportunity to act on it.

DATE _____ SIGNED X _____