

SUBSCRIBER NAME _____

KPS ID# _____

(If not issued yet, leave blank)

Please complete this form if you wish to have your monthly premium payment automatically withdrawn, changed, or cancelled from your bank account. This is an optional free service for your convenience. KPS arranges with your bank a transfer on or about the 10th of each month for the next month's coverage. The funds transfer will appear on your monthly bank statement. KPS will notify you in advance if there is to be any change in the amount of your premium.

PLEASE NOTE: **Payment for the first month's premium is required with your application.** After your application is approved, it may take approximately one month to complete the arrangement with your bank. If you receive any premium bills, it means the funds transfer process has not been completed and you should remit payment before the 10th of the month of coverage. The automatic payment system will take effect for the following months, and you will no longer receive bills.

AUTOMATIC PREMIUM PAYMENT ACCOUNT

Please fill out below to start your automatic monthly premium payment.

NAME ON ACCOUNT (print as shown on your bank statement)

BANK NAME

BRANCH NAME

BRANCH ADDRESS (exactly as shown on your bank statement)

CITY

STATE/ZIP CODE

CHECKING ACCOUNT#

ROUTING NUMBER (1st 9 digits on the bottom of check)

SIGNATURE OF ACCOUNT HOLDER(S)

SIGNATURE OF SUBSCRIBER (If different than name on account)

DATE

TO CHANGE PREMIUM PAYMENT ACCOUNT

Please fill out your **new bank** information on the left-hand side and your **old bank** information below.

NAME ON ACCOUNT

PREVIOUS BANK NAME

PREVIOUS ACCOUNT#

SIGNATURE OF PAYEE/DATE

SIGNATURE OF SUBSCRIBER/DATE

TO CANCEL PREMIUM PAYMENT ACCOUNT

I no longer wish to participate in the KPS Health Plans automatic premium payment process. Please discontinue deducting premium payments from my bank account, effective _____. I understand KPS will continue to provide health care coverage for me (and my family) and I will be billed on a monthly basis.

SIGNATURE _____

DATE _____

* As used herein, the term "bank" includes all types of financial institutions, including commercial banks, savings banks, savings and loans and credit unions. The signature(s) above gives KPS Health Plans permission to disclose the financial information for the above account to the Name on the bank account. Only billing and payment information will be given to above payee, nothing will be given regarding claims or claims payment. I have the right to revoke this permission at any time, by signing the cancellation section of my copy of this form and returning it to KPS Health Plans at the below address.