



PO Box 1090
Great Bend, KS 67530
(877) 888-6447
(620) 793-1199 fax
www.nhhealthplan.org

Administered by Benefit Management, Inc.

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

Member: _____ Member Number: _____

I hereby authorize **New Hampshire Health Plan**, hereinafter called COMPANY, to initiate debit entries to my
 Checking **Savings** account (select one) indicated below and the depository named below, hereinafter called
DEPOSITORY, to debit same to such account.

DEPOSITORY

NAME: _____ BRANCH: _____

CITY: _____ STATE: _____ ZIP: _____

TRANSIT/ABA NO.: _____ ACCOUNT NO.: _____

This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME(S): _____

DATE: _____ SIGNED: _____

Note: Person signing this form must also be on the signature card with the bank for this account.

Debit entries will occur on the 1st day of the month. If the date falls on a weekend or holiday the debit entry will occur on the first business day thereafter. All changes, including stop draft orders, must be received by the 15th of the prior month in which the premium is due. Requests received after that date cannot be honored for the next payment due date.

**Attach a voided check from
the account to be debited
here.**