



# Automatic Withdrawal Authorization Form (For Farm Bureau Health Plan)

Policyholder Name \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Policyholder SSN or Member ID \_\_\_\_\_ Policyholder Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

- ☐ New Enrollment      ☐ Update to an existing policy
- ☐ Automatic account withdrawal from policyholder's account
- ☐ Automatic account withdrawal from account other than the policyholder's

Premiums will be withdrawn monthly:

- ☐ First of the month      ☐ Fifth of the month

Select Bank Account Type:

- ☐ Checking
- ☐ Savings

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number

Bank Account Number

## Electronic Funds Transfer Automatic Payment Authorization

By providing the bank account information shown, I certify that I am the Bank Account Holder and I authorize Farm Bureau Health Plan or its administrator Wellmark, to make automatic withdrawals from the account in the amount of the periodic payment and related fees, if applicable, as they may be adjusted from time to time. This authorization for automatic withdrawals shall include authorization for automatic withdrawal of any changed amount unless it is canceled as described herein. If Bank Account Holder calls the bank to stop payment, Bank Account Holder may be required to provide the bank with a written request within fourteen (14) days after the call. Bank Account Holder will be responsible for any service fee assessed by the bank for stop payment orders. Farm Bureau Health Plan or Wellmark may also charge Bank Account Holder a returned payment fee of \$25 for any automatic withdrawal that is not honored by the bank.

I understand that automatic account withdrawal is a condition of enrolling in the Farm Bureau Health Plan. I understand that if I cancel my automatic payment and do not provide updated banking information or automatic withdrawal authorization, my coverage may be terminated. The Bank Account Holder may cancel automatic payment or provide updated banking information any time by notifying Wellmark in writing or by calling the number on the ID card by the 10th of the month prior to the next scheduled withdrawal in order to cancel automatic payment or provide new/updated banking information. If the request is not received by the 10th of the month prior to the next scheduled withdrawal, request may not be processed before the next withdrawal. The Bank Account Holder will be responsible for any fees assessed by the bank for insufficient funds or stop-payment orders made.

If at any time the member's account falls behind in payments, Farm Bureau Health Plan or Wellmark reserve the right to withdraw any amount necessary, including fees, to bring the account current with the next regularly scheduled automatic payment. In the event the Account Holder removes or fails to update banking information required for automatic withdrawal, or in the event the Account Holder does not make an electronic payment, I understand I will be switched to paper billing, and I may be subject to a paper billing processing fee in addition to the amount due for my plan. Farm Bureau Health Plan or Wellmark will not withdraw any amount above that which is due at the time of withdrawal; notice may not be provided to the bank account holder prior to said withdrawal. This authorization supersedes and replaces any previous authorization given by the Account Holder for automatic premium withdrawal.

Bank Account Holder's Name (as it appears on the account) \_\_\_\_\_

Authorized Signature of Bank Account Holder \_\_\_\_\_

Date of signature \_\_\_\_/\_\_\_\_/\_\_\_\_

Submit to: Wellmark Administrators, Inc.  
PO Box 9232 Station 4W688  
Des Moines, IA 50306-9232  
OR  
Fax: 515-376-9063