Preferred Medical Plan, Inc.
4950 SW 8th Street
Coral Gables, Florida 33134

FOR OFFICE USE ONLY
ID# _____
EFFECTIVE DATE: _____

MONTHLY AUTOMATIC PAYMENT AUTHORIZATION

If you so choose, you can have your monthly premium charged directly to your checking account. The premium will be withdrawn from your bank account on the first banking day of each month. If you wish this option, complete the instructions below.

INSTRUCTIONS

1. Fill out and sign the form below. Please use black ink.
2. Attach a copy of your first month premium check or a voided check from the account to be used for the automatic payment. We will use it as a record of your Checking account number.
3. We will communicate with your Bank to direct them to honor this authorization.
4. Provide a check for the first month premium.
5. Return this authorization form to: Preferred Medical Plan, Inc., 4950 SW 8th Street, Coral Gables, Florida 33134. Attn.: Accounts Receivables.
6. If you have questions about completing this form, call your agent or Preferred Medical Plan, Inc. at (305) 648-4011.

PLEASE PRINT

POLICY INFORMATION

Applicant Name	Member ID (if known) or Last 4 Digits of SSN
Dependent Name	Member ID (if known) or Last 4 Digits of SSN
Dependent Name	Member ID (if known) or Last 4 Digits of SSN
Dependent Name	Member ID (if known) or Last 4 Digits of SSN
Dependent Name	Member ID (if known) or Last 4 Digits of SSN
Plan Chosen	County

BANKING INFORMATION

Bank Account in Name of (if different from applicant)			
Account #	Routing #	Checking	Savings
Bank Name and Address		Monthly Premium $	

CERTIFICATION AND AUTHORIZATION

THE UNDERSIGNED HEREBY AUTHORIZES PREFERRED MEDICAL PLAN, INC. TO INITIATE DEBIT ENTRIES AND TO INITIATE, IF NECESSARY, CREDIT ENTRIES AND ADJUSTMENTS FOR ANY DEBIT TO MY ACCOUNT INDICATED BELOW AND THE FINANCIAL INSTITUTION NAMED ABOVE AND TO DEBIT AND OR CREDIT SAME TO SUCH ACCOUNT. A VOIDED CHECK FROM THE ACCOUNT TO BE USED FOR AUTOMATIC PAYMENT OR A COPY OF THE FIRST MONTH'S PREMIUM CHECK FOR NEW ENROLLEES MUST BE INCLUDED WITH THIS FORM. THE AUTHORIZATION IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL PREFERRED MEDICAL PLAN, INC. HAS RECEIVED WRITTEN NOTIFICATION FROM ME (OR EITHER OF US) OF ITS TERMINATION BY THE 10TH OF THE MONTH. ACCOUNTS ARE DRAFTED WITHIN THE FIRST FIVE (5) BANKING DAYS OF EACH MONTH. MONTHLY PREMIUM IS SUBJECT TO CHANGE WITH RATE INCREASE OR DEPENDENT CHANGE. I FURTHER AGREE THAT IF ANY SUCH CHECK BE DISHONORED, WHETHER WITH OR WITHOUT CAUSE AND WHETHER INTENTIONALLY OR INADVERTENTLY, YOU SHALL BE UNDER NO LIABILITY WHATSOVER EVEN THOUGH SUCH DISHONOR MAY RESULT IN THE CANCELLATION OF HEALTH COVERAGE.

Signature of Account Holder: _____ **Date:** _____