BAPTIST HEALTH PLAN

PHONE: 859.269.4475
TOLL FREE: 800.787.2680
FAX: 859.335.3700
651 Perimeter Drive, Suite 300 Lexington, KY 40517

I authorize Baptist Health Plan to initiate debit entries of premiums or other related payments on my behalf to the account indicated below, and authorize the financial institution named below to debit the same to such account. I understand Baptist Health Plan will deduct premium amounts as billed on the first (1st) business day of each month for that month's coverage (for example, March's premiums will draft on March 1), and will include any retroactive premiums. I understand that this authorization will continue until notified in writing to terminate the deductions, allowing reasonable time to act on my notification. I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account. **This process may take up to 30 days to begin.**

Check One: _____Begin EFT _____Change EFT

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name___________________________________

Financial Institution Address, City, State, Zip____

Account Type (Check One): _____Checking _____Savings

Bank Transit/ABA Number___________________________________

Bank Account Number______________________________________

CUSTOMER INFORMATION

Member Name____

Baptist Health Plan Group Number and Member
Number or kynect (Exchange) Reference Number____

Signature of Authorizing Individual____

Date Signed_____________________

FORWARD A VOIDED CHECK AND THIS COMPLETED FORM TO:

Baptist Health Plan
ATTN: Finance
651 Perimeter Drive, Suite 300
Lexington, KY 40517 ***- or -*** FAX TO: 859/335-4106

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