

Bluegrass Family Health

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

I authorize Bluegrass Family Health to initiate debit entries of premiums or other related payments on our behalf to our account indicated below, and authorize the financial institution named below to debit/credit the same to such account. I understand Bluegrass Family Health will deduct premium amounts as billed on the first (1st) business day of each month for that month's coverage (for example, December's premiums will draft on December 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.

Check one: Begin EFT Change EFT

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____

Address, City, State, Zip _____

Account Type (check one): Checking Savings

Bank Transit/ABA Number: _____

Account Number: _____

CUSTOMER INFORMATION

Group Name: _____

Bluegrass Family Health Group Number(s) -- list all applicable, including any subgroups or COBRA groups: _____

Effective Date of this addition or change: _____

Name of Authorizing Individual: _____

Signature of Authorizing Individual: _____

Date Signed: _____

FORWARD A VOIDED CHECK AND THIS COMPLETED FORM TO:

Bluegrass Family Health

ATTN: Finance

651 Perimeter Drive, Suite 300

Lexington, KY 40517

- or -

FAX TO: 859/335-4106

You will be notified when EFT takes effect.

RA09/04.1