HEALTH PLANS

AUTHORIZATION REVOKED (PAYOR)

I hereby authorize Ohio Farm Bureau Health Plans ("OHFBHP") to cancel debit entries to the account identified below for the monthly payment on the health or dental coverage set forth below. I acknowledge that I am signing this agreement on behalf of all covered individuals, and signatories to the account, and am authorized to do so.

I understand that I am not the member and thus not authorized to cancel coverage on behalf of the member. The member will be given notice in writing as to the continuance of their coverage.

As Payor for the health or dental coverage stated below, I hereby agree to these terms and conditions.

Health ____ Dental ____

Applicant/Member Name _____

Applicant/Member Identification # _____

_____ _____
Payor Bank Routing Number Payor Account Number

_____ _____
Signature of Payor (Required) Print Payor Name (Required)

_____
Date

Ohio Farm Bureau Health Plans
PO Box 1424
Columbia, TN 38402-1424
Fax 931-560-4278
Billingforms@fbhp.com