



PO Box 1090
Great Bend, KS 67530
Toll Free: (844) 728-7896
TTY: (844) 728-7897
Fax: (620) 793-1199

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize **New Mexico Medical Insurance Pool ("NMMIP")** to initiate debit entries from my account and Depository designated below. Pursuant to my election, debits will be drawn on the first, second or third Friday of each month unless the date falls on a holiday; then it will be drawn the next business day.

INSURED'S NAME: _____ Insured's Social Security Number: _____

I elect to have funds withdrawn from my account on:

- 1st Friday of the month 2nd Friday of the month 3rd Friday of the month

Indicate the type of account by checking the appropriate box: Checking Savings

ATTACH A VOIDED CHECK
A deposit ticket will not be accepted

The voided check must match the account number given on this form.

DEPOSITORY NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

TRANSIT/ABA NO. _____ ACCOUNT NO. _____

This authority is to remain in full force and effect until NMMIP and Depository have received written notification from me of this agreement's termination in such time and in such manner as to afford NMMIP and the Depository reasonable opportunity to act upon the request.

X _____ DATE _____

Signature must be from a person who has authority to sign on the account to be drafted.