



### AUTHORIZATION REVOKED (PAYOR)

I hereby authorize Missouri Farm Bureau Health Plans ("MOFBHP") 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

Missouri Farm Bureau Health Plans  
PO Box 1424  
Columbia Tn 38402-1424  
Fax 931-560-4278  
Billingforms@fbhp.com