COX HEALTH SYSTEMS INSURANCE COMPANY
PO BOX 5750
SPRINGFIELD, MO 65801-5750

AUTHORIZATION AGREEMENT FOR INDIVIDUAL DIRECT DEBIT

MEMBER NAME____

☐ New Application ☐ Change account information ☐ Terminate Direct Debit

I (we) hereby authorize Cox Health Systems Insurance Company ("Cox") to initiate debit entries, and the Financial Institution named below to debit, my/our Checking/Savings account in the amount of my/our monthly premium on the 1st of each month, which shall be applied by Cox for the payment of my/our health insurance premium. **I/We acknowledge and agree that the timely payment of premiums is my/our sole responsibility and that Cox is not responsible for a policy cancellation due to nonpayment if the direct debit request is presented but not honored or for any other reason the premium is not timely paid.**

FINANCIAL INSTITUTION ____

CITY_______________________ STATE________________ ZIP ________________

TRANSIT/ABA NO.________________________ ACCOUNT NO.__________________

This authorization to debit my/our account will remain in full force and effect until Cox and the above-named Financial Institution receive written notice of termination from me (or either of us), which is effective ten (10) days after receipt or first date on which Cox and the Financial Institution have a reasonable opportunity to act on it, whichever is later.

NAME(S)____

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SIGNED____ DATE_____________

SIGNED____DATE_____________

Attach voided check here

For Office Use Only
MEMBER NO.____________________________________