

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: \_\_\_\_\_ fax: \_\_\_\_\_

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** – monthly or quarterly (every three months).

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

**Please make your check payable to: Regence BCBSO**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

**Thank you for choosing...**





# Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon  
100 SW Market Street  
Portland, Oregon 97207-1271  
Mail form to: PO Box 1271 MS:E8U  
Portland, OR 97207-1271

## Individual Application and Standard Health Statement

### SECTION 1 - INSTRUCTIONS

- ◆ Please read carefully.
- ◆ Use ink to complete and sign this application. An application completed in pencil will be returned to you.
- ◆ Make sure all sections of the application are answered completely.
- ◆ If you need assistance completing this application, please contact your insurance producer or call Individual Marketing at 1-888-REGENCE.

Yes  No I want to do my part for the environment and reduce waste. Please send my Explanation of Benefits (and when possible, other communications) electronically.

EFFECTIVE DATE: Upon approval, you will be eligible for an effective date of the first of the month following the date the completed application was received in our office, unless otherwise indicated. Incomplete applications may receive a later effective date. Requested Effective Date \_\_\_\_\_

#### I am applying for:

- New enrollment       Addition of a spouse/domestic partner and/or dependent child to my existing policy  
 Change to existing individual plan or deductible

### SECTION 2 - PLAN SELECTION (Detailed benefit information can be found online at [www.regence.com](http://www.regence.com))

#### BASE PLANS (select ONE medical plan)

##### Evolve Core

- \$1,000 deductible per member (maximum of 3 deductibles per family)  
 \$2,500 deductible per member (maximum of 3 deductibles per family)  
 \$5,000 deductible per member (maximum of 3 deductibles per family)  
 \$7,500 deductible per member (maximum of 3 deductibles per family)  
 \$10,000 deductible per member (maximum of 3 deductibles per family)

##### Evolve Plus

- \$1,000 deductible per member (maximum of 3 deductibles per family)  
 \$2,500 deductible per member (maximum of 3 deductibles per family)  
 \$5,000 deductible per member (maximum of 3 deductibles per family)  
 \$7,500 deductible per member (maximum of 3 deductibles per family)

##### Evolve HSA

- |   |  |
|---|--|
| <input type="checkbox"/> \$1,500 self-only deductible / 50% coinsurance | <input type="checkbox"/> \$3,000 family deductible / 50% coinsurance |
| <input type="checkbox"/> \$1,500 self-only deductible / 80% coinsurance | <input type="checkbox"/> \$3,000 family deductible / 80% coinsurance |
| <input type="checkbox"/> \$3,500 self-only deductible / 50% coinsurance | <input type="checkbox"/> \$7,000 family deductible / 50% coinsurance |
| <input type="checkbox"/> \$3,500 self-only deductible / 80% coinsurance | <input type="checkbox"/> \$7,000 family deductible / 80% coinsurance |

##### Evolve HSA 100

- \$5,000 self-only deductible  
 \$10,000 family deductible

#### DENTAL OPTIONS (select ONE of the following dental options)

- Dental Option 1** - 100/80/50; \$750 annual maximum benefit that may increase over time to \$1,500  
 **Dental Option 2** - 100% of first \$200 and 50% of next \$1,100 (\$750 annual maximum benefit)  
 **No Dental**



**SECTION 3 - ENROLLMENT INFORMATION**

**LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED**

Eligible family members include a spouse/domestic partner, and/or any unmarried child who is under age 23, financially dependent upon you, or who is medically certified as disabled and dependent upon you for support. Copy of certification required.

Last Name	First Name, MI	Gender	Age	Height	Weight	Birthdate	Social Security Number
Applicant							
<input type="checkbox"/> Spouse <input type="checkbox"/> Non-Certified Domestic Partner* <input type="checkbox"/> Certified Domestic Partner							
Child 1							
Child 2							
Child 3							

Explain the relationship to the applicant for any person(s) listed above whose last name is different from the applicant's. We may request a Certificate of Dependency form. \*Non-Certified Domestic Partners must submit an Affidavit of Domestic Partnership.

**OREGON RESIDENCE ADDRESS**

To be eligible to apply for our individual plans, you must reside in our service area and continue to live in our service area for six months out of the year. A photocopy of a valid Oregon state driver's license, identification card, or current utility bill with name and address may be requested as proof of residency.

Residence Street Address		Mailing Address (if different than residence street address)	
City, State, ZIP Code		E-Mail Address (will not be disclosed outside of the company)	
Home Phone Number	Work Phone Number	County	

**SECTION 4 - OTHER COVERAGE INFORMATION**

- Are you or any dependents who are applying for coverage currently covered on any group, individual or self-insured medical plan? .....  Yes  No  
 If yes, do you intend to replace your current plan with this contract?.....  Yes  No
- Are you currently enrolled in a Regence BlueCross BlueShield of Oregon Individual medical plan and wish to cancel that coverage?.....  Yes  No

**If you answered yes, please sign the statement below:**

I wish to terminate my current individual medical coverage from Regence BlueCross BlueShield of Oregon on the effective date of this individual policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Regence BlueCross BlueShield of Oregon Individual Plans contain a 6-month preexisting condition limitation period. Please provide the following information for all applicants, and attach a copy of your Certificate of Coverage from your current or prior carrier or a similar document showing the beginning and ending dates of your current coverage, if applicable.

Name (First Last)	Insurance Company	Policy Number	Dates of Coverage		Type of Coverage
			Date Coverage Began MM/DD/YYYY	Date Coverage Ended (indicate Active if you are currently covered) MM/DD/YYYY	
1.					<input type="checkbox"/> Employer Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicare <input type="checkbox"/> COBRA <input type="checkbox"/> High Risk Pool <input type="checkbox"/> Other (describe)
2.					
3.					
4.					
5.					



**SECTION 5 - OREGON STANDARD HEALTH STATEMENT**

Has any insurance company, within the last five years, postponed, refused, restricted or increased premium for life or health insurance coverage for health reasons for you or any of your family members to be covered? .....  Yes  No

If "yes", indicate name of person affected, reason for action, and name of insurance company \_\_\_\_\_

**Notice to Applicant:** You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or to any blood relative. You are not required to disclose any decision by an insurance company that is based on a genetic test or on genetic information.

Please mark "Yes" or "No" for each item (for you and any family members requesting coverage). Provide details on Page 5 to any questions answered "Yes." **(For the purpose of these questions, chronic means persistent, continuous, periodic, or a combination of any of these terms.)**

Within the last five years, has anyone listed on this application had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional; or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement related to any of the following conditions:

	Yes	No		Yes	No
1. AIDS, ARC, HIV positive.....	<input type="checkbox"/>	<input type="checkbox"/>	26. High cholesterol (if "Yes", record last reading on page 5).....	<input type="checkbox"/>	<input type="checkbox"/>
2. Alcohol/chemical/drug abuse/habit.....	<input type="checkbox"/>	<input type="checkbox"/>	27. High blood pressure (if "Yes", record last reading on page 5).....	<input type="checkbox"/>	<input type="checkbox"/>
3. Anemia/chronic fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	28. Kidney/kidney stones.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Appendicitis/chronic abdominal pain.....	<input type="checkbox"/>	<input type="checkbox"/>	29. Knee/shoulder/hip/other joints.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Back/neck/spine.....	<input type="checkbox"/>	<input type="checkbox"/>	30. Liver condition/hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Birth defect/congenital deformities.....	<input type="checkbox"/>	<input type="checkbox"/>	31. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Bladder/urinary tract.....	<input type="checkbox"/>	<input type="checkbox"/>	32a. Mental/emotional condition/depression.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Blood/circulatory.....	<input type="checkbox"/>	<input type="checkbox"/>	32b. Therapy/counseling within last 5 years (if "Yes", record date of last session on page 5).....	<input type="checkbox"/>	<input type="checkbox"/>
9. Bone/orthopedic.....	<input type="checkbox"/>	<input type="checkbox"/>	33. Neurological condition/disease/injury.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Brain disease or injury/concussion.....	<input type="checkbox"/>	<input type="checkbox"/>	34. Phlebitis/blood clot.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Breast (lumps or masses).....	<input type="checkbox"/>	<input type="checkbox"/>	35. Osteoarthritis/osteoporosis/osteopenia.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	36. Prostate/elevated PSA/prostatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Chemotherapy/radiation treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	37. Reproductive system disorder/infertility.....	<input type="checkbox"/>	<input type="checkbox"/>
14a. Colon/rectum/intestine/bowel.....	<input type="checkbox"/>	<input type="checkbox"/>	38. Chronic respiratory/lung condition.....	<input type="checkbox"/>	<input type="checkbox"/>
14b. Blood in stool.....	<input type="checkbox"/>	<input type="checkbox"/>	39. Rheumatoid arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
15. Convulsion/seizures/epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	40. Sexually transmitted disease(s).....	<input type="checkbox"/>	<input type="checkbox"/>
16. Diabetes/sugar in urine.....	<input type="checkbox"/>	<input type="checkbox"/>	41. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
17. Chronic ear/nose/throat/tonsil condition/disease/disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	42. Sleep apnea/chronic sleep disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
18. Eating disorders such as, but not limited to, anorexia or bulimia.....	<input type="checkbox"/>	<input type="checkbox"/>	43. Stomach disorders/ulcer/acid reflux.....	<input type="checkbox"/>	<input type="checkbox"/>
19. Emphysema/asthma/chronic lung disease (COPD).....	<input type="checkbox"/>	<input type="checkbox"/>	44. Stroke/paralysis/seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
20. Endocrine/gland/hormone system.....	<input type="checkbox"/>	<input type="checkbox"/>	45. Tumors.....	<input type="checkbox"/>	<input type="checkbox"/>
21. Disease or injury of eye/cataract/glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	46. TMJ/jaw joint.....	<input type="checkbox"/>	<input type="checkbox"/>
22. Gallbladder/pancreatic disease.....	<input type="checkbox"/>	<input type="checkbox"/>	47. Weight fluctuation (+/-20 lbs.).....	<input type="checkbox"/>	<input type="checkbox"/>
23. Chronic headaches/migraines.....	<input type="checkbox"/>	<input type="checkbox"/>	48. Cosmetic surgery/implants, use of prosthetic devices/limbs.....	<input type="checkbox"/>	<input type="checkbox"/>
24. Heart/chest pain/angina.....	<input type="checkbox"/>	<input type="checkbox"/>			
25. Hernia.....	<input type="checkbox"/>	<input type="checkbox"/>			



**SECTION 5 - OREGON STANDARD HEALTH STATEMENT (continued)**

Yes No

49. Has any person on this application used tobacco products in any form within the last 5 years?.....

If "yes" Name \_\_\_\_\_ type of product \_\_\_\_\_

Name \_\_\_\_\_ type of product \_\_\_\_\_

Name \_\_\_\_\_ type of product \_\_\_\_\_

50. Please provide the following information for each female on this application:

Family Member Name(s):				
a. Initial menstrual cycle begun?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Date of last menstrual period. mm/dd/yyyy				
c. If (b) is more than 35 days ago, please explain:				
d. Excessive or absent menstrual bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. If (d) is yes, please explain:				
Date of last DEPO Provera shot? mm/dd/yyyy				
Abnormal Pap smears?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prior Cesarean section or miscarriage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

51. Is any person on this application now pregnant?.....  Yes  No

If "yes" Name \_\_\_\_\_ Due date \_\_\_\_/\_\_\_\_/\_\_\_\_

52. Is any person on this application, including male applicants and dependent males or females, responsible for a current pregnancy?.....  Yes  No

If "yes" Name \_\_\_\_\_ Due date \_\_\_\_/\_\_\_\_/\_\_\_\_

53. Please provide the following information for each person on this application. Within the last five years, has any person on this application:

a. Had any medical advice, diagnosis, care or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not listed on page 3 & 4?.....  Yes  No

b. Had chronic cough, fatigue, diarrhea, or enlarged glands?.....  Yes  No

c. Been advised to have or contemplated having an operation or medical procedure not yet performed?.....  Yes  No

d. Been scheduled to see a health care provider at a future date?.....  Yes  No

e. Taken any prescription medication on a regular basis?.....  Yes  No



**SECTION 5 - OREGON STANDARD HEALTH STATEMENT (continued)**

54. List all medications currently being taken by any person on this application:

Name	Medications	Prescribed by (name/address/telephone number)	Date prescribed

Please provide specific details below to each question answered "yes" on pages 3 - 5. Include insured/applicant's name; the number of the question to which you answered "yes"; the condition, treatment and date; the result of treatment, including any medications; and the name, address and telephone number of the attending physician, other health care provider, or clinic/hospital.

**HEALTH HISTORY DETAILS**

Name	Question Number	Start to end dates	Condition	Treatment including medications	Final result Ongoing or Resolved Please check	Attending physician/health care provider or hospital (name/address/telephone)
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	
					<input type="checkbox"/> Ongoing <input type="checkbox"/> Resolved	

Attach additional pages if necessary.  I have attached \_\_\_\_\_ page(s).

Name, address, and telephone number of medical provider(s) with current medical record/history:

\_\_\_\_\_

\_\_\_\_\_

**SECTION 6 - PRODUCER CERTIFICATION**

If you have a producer, that producer may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueCross BlueShield of Oregon. Incentives may be based on any of several factors, including the products you buy, your producer's volume of business with Regence BlueCross BlueShield of Oregon, and the other services your producer provides you. These incentives may have an indirect impact on your rates. For more information, please contact your producer.

**FOR PRODUCER USE ONLY**

I, (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence BlueCross BlueShield of Oregon. I have informed the applicant that the effective date of coverage is assigned only by Regence BlueCross BlueShield of Oregon and provided the Oregon Disclosure Information required.

**I certify that the information supplied to me by the applicant has been truly and accurately recorded here.**

Producer Name (please print or type)	Regence Producer Number
Producer's Signature (Required)	Date (Required)

**X**

**Producer: COLLECT NO PREMIUM WITH APPLICATION**



**SECTION 7 - CERTIFICATION, AUTHORIZATION AND SIGNATURE**

Be sure to sign and date the application below. Spouse/Domestic Partner and/or dependent's (age 18 - 23) signature is required, if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Use and Disclosure of Protected Health Information":

**CERTIFICATION OF COMPLETION AND CORRECTNESS**

I affirm that the answers given in this application are true, complete, and correct. I am providing these answers as part of the application procedure required by Regence BlueCross BlueShield of Oregon to enroll in their coverage. I understand that Regence BlueCross BlueShield of Oregon will rely on each answer in making coverage and rating determinations. For the protection of all our members, fraud or misrepresentation of material fact by me for the purposes of defrauding Regence BlueCross BlueShield of Oregon may result in Regence BlueCross BlueShield of Oregon taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. If coverage is rescinded for fraud or intentionally misleading statements, Regence BlueCross BlueShield of Oregon will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Regence BlueCross BlueShield of Oregon in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Regence BlueCross BlueShield of Oregon. Regence BlueCross BlueShield of Oregon may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file. I further affirm that I received a disclosure statement from Regence BlueCross BlueShield of Oregon or its authorized insurance producer describing the individual contract.

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the application form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.\*

Health information requested or disclosed may be related to treatment or services performed by:

- ◆ a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- ◆ a clinic, hospital, long-term care or other medical facility;
- ◆ any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- ◆ an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Regence BlueCross BlueShield of Oregon may deny coverage, modify or cancel coverage and/or take any other legal action available to us by law.

\*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at [www.or.regence.com](http://www.or.regence.com) or by telephone request at 1 (800) 365-3155.

**THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES**

(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session.)

**SIGNATURES**

Signature of applicant, parent or legal guardian if applicant is under 18 years of age or legally incompetent*	Relationship	Date
<b>X</b>		
Signature of applicant's legal spouse or eligible domestic partner*		Date
<b>X</b>		
Signature of dependent(s) between 18 and 23 years of age*		Date
<b>X</b>		
Signature of dependent(s) between 18 and 23 years of age*		Date
<b>X</b>		

**\*If signature by a personal representative of the member/enrollee please complete the following:**

Personal Representative's Name (please print) \_\_\_\_\_

Relationship to Individual \_\_\_\_\_ (Attach legal documentation if other than parent of a minor child)

If additional health information is required to qualify you or a family member for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.



**SECTION 8 – PREMIUM BILLING OPTIONS (if application is approved)**

**BILLING ADDRESS** (complete only if billing should be sent to an address other than the Residence Street Address listed on the front of the application.)

Name	Relationship to Applicant
------	---------------------------

Address	City, State, ZIP Code
---------	-----------------------

Yes  No Is your employer reimbursing or paying for any portion of this policy's premium? Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees.

**Please indicate which billing option you want to use. (If billing option is left blank, your policy will automatically default to Monthly Billing).**

- Monthly Billing
- FHIAP ID# \_\_\_\_\_ (please attach a copy of the signed FHIAP Certificate of Eligibility listing all eligible parties, to this application).
- Quarterly Billing
- SurePay (monthly automatic bank deduction)

**Note: If selecting SurePay, please fill out the information below.**

SUREPAY is a simple and convenient way to keep your health coverage in force. If you select the SUREPAY option of paying for your Regence BlueCross BlueShield of Oregon health insurance the payment will be deducted automatically on the draft date you choose below. This will provide several advantages to you:

- ◆ Your payment will always be made on time (if funds are available in your account).
- ◆ You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- ◆ Your monthly bank statement will show a withdrawal notation. This will serve as receipt of payment.
- ◆ Claims will be paid promptly due to your policy always being paid current.

**GETTING STARTED IS EASY** by mail or phone:

1. **Complete**, date and sign the SurePay Authorization information below.
2. **Write "void"** on one of your checks and return your "voided" check with this application (not a deposit slip). *For savings account please provide proof of ownership of the account.*

**SUREPAY AUTHORIZATION**

**Please indicate which day you want your payment made.**

- 5th of the month** - will pay the current month's charges
- 15th of the month** - will pre-pay the next month's charges
- 25th of the month** - will pre-pay the next month's charges

**AUTHORIZATION TO MY BANK**

Checking Account  Savings Account

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueCross BlueShield of Oregon, Portland, OR. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Financial Institution	Transit/Routing Numbers	Account Number

Account Holder's Name (please print)

Account Holder's Authorized Signature(s) - as it appears on bank records

Date

