



Premium Payment – Direct Debit Authorization Form

*****Please staple voided check to this form*****

Member Name: _____ **Member ID#:** _____
(Please Print)

Start Date _____

I (we) hereby authorize **PRIMARY HEALTH NETWORK, INC.** to initiate debit entries to my (our) _____ **Checking** _____ **Savings** account (please check one) on the first business day of the month from your depository financial institution, hereinafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U. S. Law. Member will be responsible for all bank charges associated with insufficient fund fees.

This authorization is to remain in full force and effect until **PRIMARY HEALTH NETWORK, INC.** has received written notification of its termination in such time and such manner as to afford **PRIMARY HEALTH NETWORK, INC.** and depository a reasonable opportunity to act on it. Please see **IMPORTANT** note below.

IMPORTANT NOTE: ANY CHANGES TO THE DEBIT AUTHORIZATION AFTER THE 15TH OF THE MONTH WILL NOT BE ACTED UPON UNTIL THE FIRST BUSINESS DAY OF THE FOLLOWING MONTH.

******FORM CANNOT BE PROCESSED WITHOUT A VOIDED CHECK******

Signature: _____ **Date:** _____