AUTHORIZATION AGREEMENT FOR PRE-AUTHORIZED PAYMENTS

☐ **Enrollment** ☐ **Change**

With MD-Individual Practice Association, Inc. (M.D. IPA); Optimum Choice, Inc. (OCI); or MAMSI Life and Health Insurance Company (MLH) Indemnity Products, you can have your monthly premiums automatically deducted from your bank account. The deduction occurs on the 8th of each month (or the 23rd for groups effective on the 15th). This automatic deduction insures that your coverage is not terminated due to non-payment.

If you would like to participate, simply complete this form, attach a voided check and mail it to Group Services Department, Attn: Auto-Withdrawal Program, P.O. Box 931, Frederick, MD 21705-0931. If you have any questions, please call your Sales Representative or Group Services Representative. **It will take approximately three weeks from receipt of this form before the first withdrawal is made.** Thank you.

Please complete the following information in its entirety.

ABOUT YOUR POLICY:
Company in which you are enrolling (circle one) OCI M.D. IPA MLH

Group/Individual Name: ______________________ Group Number: ____________

ABOUT YOUR BANK ACCOUNT:

Account Name: ______________________ (Check one) ☐ Checking ☐ Savings

Bank Name: ______________________ City and State: ____________

Account Number: ______________________ Bank Routing Number: ____________

Please attach a voided check or copy of a check (for checking accounts) or a deposit ticket (for savings accounts). WE CANNOT PROCESS THIS APPLICATION WITHOUT ONE OF THESE ITEMS.

Please read the following agreement very carefully. By signing this application, you agree to the following terms:

I (we), the undersigned, hereby authorize M.D. IPA/OCI/MLH (hereinafter called "COMPANY") to initiate debit entries to my (our) account described above and authorize the above mentioned financial institution to debit the same to such account.

I (we) give COMPANY permission to deduct the full amount of my most recent monthly invoice unless I contact them and make other arrangements. (Policies which are billed quarterly give permission to deduct one month's premium per month.)

This authorization is to remain in full force and effect until the underlying obligation has been satisfied or until COMPANY has received written notification of its termination. This authorization will automatically renew each contract year without written consent from the account holder.

Signature(s): ______________________ Date: ____________

Printed Name(s): ______________________ Daytime Phone Number: ____________

P.O. Box 931 • Frederick, MD 21705-0931 • (240) 379-1849 • Fax: (301) 360-8917