



**COX HEALTH SYSTEMS HMO, INC.**  
**PO BOX 5750**  
**SPRINGFIELD, MO 65801-5750**

**AUTHORIZATION AGREEMENT FOR DIRECT DEBIT**

GROUP NAME \_\_\_\_\_

New Application     Change account information     Terminate Direct Debit

I (we) hereby authorize Cox Health Systems HMO, Inc. ("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 1<sup>st</sup> 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) \_\_\_\_\_

\_\_\_\_\_

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

**Attach voided check here**

<p><i>For Office Use Only</i> GROUP NO. _____</p>
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