

OKLAHOMA HEALTH INSURANCE HIGH RISK POOL

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize the Oklahoma Health Insurance High Risk Pool to initiate debit entries to my account indicated below, and the depository named below to debit the same to such account. Debits will be on the 7th of every month unless it falls on a holiday or weekend, then it will be the next business day.

INSURED'S NAME: _____ Insured's Social Security Number: _____

Please indicate the type of account. Checking Savings

<p>ATTACH A VOIDED CHECK A deposit ticket will not be accepted</p>

The voided check must match the account number given on this form.

DEPOSITORY
NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

TRANSIT/ABA NO. _____ ACCOUNT NO. _____

This authority is to remain in full force and effect until the Oklahoma Health Insurance High Risk Pool and depository have received written notification from me of its termination in such time to allow the Oklahoma Health Insurance High Risk Pool and depository a reasonable opportunity to act on it.

SIGNED **X** _____

DATE _____

Signature must be from a person who has authority to sign on the account to be drafted.