JOHNS HOPKINS
HEALTH PLANS

Bank Account Withdrawal Pre-Authorization Form

Member Information

Member Name _____   ID Number _____

Financial Institution Information

Name of Account Holder _____

Financial Institution's Name_____

Street Address_____

City / State / Zip_____

Phone Number_____

Account Type (check one): _____Checking   _____Savings

Account #: _____   Routing #: _____

For a checking account, include a voided check (below). For a savings account, request and submit a letter from your financial institution including name on the account, account number, routing number and type of account. This information will be used to verify your account.

I authorize Johns Hopkins Advantage MD (HMO) or Johns Hopkins Advantage MD (PPO) to deduct my monthly plan premium from my bank account. I understand my account will be deducted on the 5th of the month or the next banking day.

X_____Date _____

(account holder, please sign as signature appears on signature card at bank.)

Please tape (do not staple) a blank, voided check in this space.

Do not use a checking deposit slip.

Please return to: Johns Hopkins Advantage MD, P.O. Box 3538, Scranton, PA 18505