

## 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 5<sup>th</sup> 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**