Please send completed form and voided check to

Interactive Medical Systems

Attention: COBRA Department

PO Box 1349, Wake Forest, NC 27588

Automatic Payment Withdrawal Authorization Form

Section I. Participant Information

Check ONE ☐ Initial Authorization ☐ Discontinue ☐ Change

First Name MI Last Name Phone Number

Street City State Zip

Social Security Number

Section II. Your Bank Account Information. <u>You must include a voided check with the completed form.</u>

A. Type of Account (Check ONE) ☐ Checking ☐ Savings

B. Bank Account Number _____

C. ABA Routing Number _____

D. Name(s) on Bank Account _____

E. Bank Name _____

F. Bank Address _____
Street City State Zip

Section III. Direct Debit From Your Account

By signing this form, I/we hereby authorize IMS, to make automatic withdrawals of funds from the account listed above for the amount due and payable to IMS or for the amount of my insurance premium. This authorization is effective as of the date in the signature block below and is valid until I provide written or verbal notice of cancellation or change to IMS. If an automatic withdrawal is unsuccessful, IMS will contact me in writing to make other arrangements to pay the amounts necessary to satisfy the third party payment obligations.

Please sign exactly how signature appears on bank records

Signature _____ Date _____

Signature, if Joint Account _____ Date _____