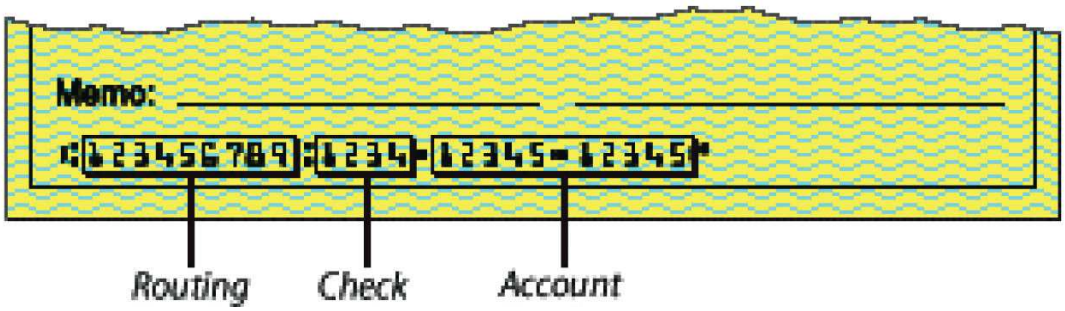
ODS Health
601 S.W. Second Ave.
Portland, OR 97204

AUTHORIZATION AGREEMENT FOR AUTOPAY (EFT)

1. Complete and sign the authorization form
2. Attach a copy of a VOIDED personal check from the account to be used
3. Fax to ODS at 503-243-3949 Attn: Indv. Sales

This Request is:
New ☐ Change ☐



Initial Premium Payment
Complete and authorize below for the bank deduction for your initial premium payment
Account Holder_____
Bank Name_____
Bank Routing #_____**Account #**_____

Recurring Premium Payment – please choose one of the three options
1. _____Continued draft _____Same Bank _____ Different Bank (indicated below)
2._____ Direct Bill Monthly
3. _____ Direct Bill Quarterly
Account Holder_____
Bank Name_____
Bank Routing #_____**Account #**_____

I authorize ODS Health to charge my (individual or joint) checking account for monthly health premium for the above individual. I also authorize my bank named here to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account is charged.

Authorizing payment does not guarantee coverage. The first monthly or quarterly premium amount will not be debited from your account until your application for individual health plan coverage has been approved by ODS Health Underwriting. You will be notified in writing of your application status within 15 business days from receipt.