HEALTH INSURANCE PROGRAM OF IOWA

BANK SERVICE PLAN AUTHORIZATION FORM

To: The financial institution named on page 2 of this form.

So that you may comply with your depositor's request, this Pool agrees:

(a) To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, order or direction to debit an account purporting to be executed by this Pool and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

(b) In the event that any such check, draft, order or direction shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in forfeiture of that insurance.

(c) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your action taken pursuant to the foregoing request or in any manner arising by reason of your participating in the foregoing plan of premium collection.

Health Insurance Program of Iowa • P.O. Box 1090 • Great Bend, KS 67530

REQUEST FOR BANK SERVICE PLAN

To Health Insurance Program of Iowa: Please use your Bank Service Plan to make payments by withdrawing funds by automatic debit entry from the account of:

Name as Shown on Account | Insured / Applicant

Name of Financial Institution | Branch

City | State | Zip

Transit/ABA No. ______________________ Account No. ______________________

Please indicate below the type of account to be debited.

Checking ☐ Savings ☐

As a convenience to me, I authorize you to pay and charge to my account automatic debit entries made upon my account by, and payable to, the order of Health InsuranceProgram of Iowa. I agree that your rights with respect to each such charge will be the same as if it were personally executed by me. **This authorization is to remain in effect until you receive 15 days' written notice from me to revoke it.**

X ______________________ X ______________________

Authorized signature as shown on the account | Date

ATTACH A VOIDED CHECK HERE

We will withdraw from your account the first Wednesday of each month except when it falls on the 1st, 2nd, or 3rd. In that case, we will then withdraw on the second Wednesday of the month.
If you have any questions call our customer service at 1.877.793.6880

Please return the Bank Service Plan to:
Health Insurance Program of Iowa
P. O. Box 1090
Great Bend, KS 67530