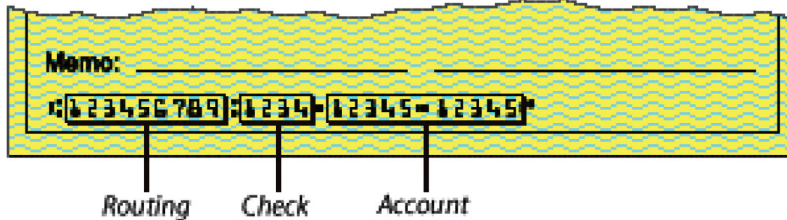
AUTHORIZATION AGREEMENT FOR AUTOPAY (EFT)

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. Mktg

THIS REQUEST IS:
NEW ☐ CHANGE ☐



Name of Applicant______________________________________ **SSN**________________________________

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 (add $5 administrative fee per month)
3. _____ Direct Bill Quarterly (add $5 administrative fee per quarter)
Account Holder____
Bank Name____
Bank Routing #__________________________________**Account #**_________________________________

I authorize ODS to charge my (individual or joint) checking account for monthly insurance 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.

Initial payment authorized by:____
(signature of account holder)

Recurring payment authorized by:____
(signature of account holder)

Authorizing payment does not guarantee coverage. The first month or quarterly premium amount will not be credited to your account until your application for individual health insurance coverage has been approved by ODS Underwriting. You will be notified in writing of your application status no later than 60 days from receipt. If you application is approved, the coverage effective date will be the 1st day of the month following approval. If your application is not approved, you will be notified in writing, and your account will not be debited.