



OPTIONAL MONTHLY AUTOMATIC  
PAYMENT AUTHORIZATION

**Individual and Family HMO Plan**

If you so choose, you can have your monthly payment fees charged directly to your checking account. The prepayment fees will be withdrawn from your bank account on the first banking day of each month. If you wish this option, complete the information below.

**Other than premiums for a sole proprietor, Vista Healthplan of South Florida, Inc. will not withdraw Individual plan premiums from a Business Account.**

**INSTRUCTIONS**

1. Fill out and sign the form below. Please use **black ink**.
2. Attach a **Blank Check** from your checking account and write "VOID" on it. We will use it as a record of your checking account number. **DO NOT** submit your deposit slip.
3. We will communicate with your bank to direct them to honor this authorization.
4. Send a check for the first month's prepayment fees.

5. If you are returning this authorization separately from your Individual and Family HMO Application, please mail to:  
**Vista Healthplan of South Florida, Inc.  
300 South Park Road  
Hollywood, Florida 33021  
ATTN: Individual Business Unit – 1<sup>st</sup> Floor**
6. If you have questions about completing this form, call your agent, broker, or Vista Healthplan of South Florida at 1-800-441-5501.

ATTACH VOIDED CHECK HERE

**PLEASE PRINT**

Applicant Name	Social Security Number of Applicant
(1) Dependent Name	(1) Social Security Number of Dependent
(2) Dependent Name	(2) Social Security Number of Dependent
(3) Dependent Name	(3) Social Security Number of Dependent
(4) Dependent Name	(4) Social Security Number of Dependent
Bank Account in Name of (if different from applicant)	Social Security Number on Bank Account
Account Number	
Bank Name and Address	
Vista Healthplan of South Florida, Inc. Use Only	

As a convenience to me, I request and authorize you to pay and charge to the above account checks drawn on that account by and payable to the order of "Vista Healthplan of South Florida, Inc" provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check. **NOTE: If funds are drawn from a business account, I certify by signing below that I am the business owner and the payments are for myself and /or immediate family member(s). I understand that payments from a business account are not for employees or others outside the immediate family.**

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.

**X**

Signature of Account Holder

Date