One-Time Direct Debit Authorization

Section 1: Member/Applicant Information (please print)

Member/Applicant Name (First, Middle Initial, Last)			Phone Number ( )
Street Address	City	State	Zip Code

Section 2: One-Time Direct Debit Authorization

I hereby authorize MVP Health Care to withdraw the amount due to MVP immediately upon receipt of this authorization for the provision of health benefits.

Signature Date

In the case of an automatic bank debit form of payment, it shall be the customer's responsibility to verify whether this payment is properly debited from their bank account. This authorization is for a one-time only debit for the initial premium payment.

This Direct Debit Authorization must be sent with your completed Enrollment form. Please follow the enrollment instructions included with this packet.

Please keep a copy of this Authorization for your records.

▼ Staple a voided check or photocopy of a voided check below. ▼