



PRE-ARRANGED WITHDRAWALS AUTHORIZATION FORM

I hereby authorize Patriot Health Insurance Company, Inc. of Manchester New Hampshire, to initiate withdrawals each month for Premium Payments against the bank account of:

Bank Name: _____

Bank Address: _____

City/State/Zip: _____

Phone Number: _____

Bank Info: Routing #: _____ Account #: _____

Type of Account: Checking Savings

Monthly withdrawals are done on approximately the 1st of every month.

This authorization is to remain in effect until Patriot Health Insurance Company, Inc. is given 30 days written notice of termination.

Company Name: _____

Address: _____

City/State/Zip: _____

Print Name: _____

Authorized Signer: _____ Date: _____