



AUTHORIZATION REVOKED (PAYOR)

I hereby authorize ALFA Health Plans ("ALFAHP") to cancel debit entries to the account identified below for the monthly payment on the health or dental coverage set forth below. I acknowledge that I am signing this agreement on behalf of all covered individuals, and signatories to the account, and am authorized to do so.

I understand that I am not the member and thus not authorized to cancel coverage on behalf of the member. The member will be given notice in writing as to the continuance of their coverage.

As Payor for the health or dental coverage stated below, I hereby agree to these terms and conditions.

Health _____ Dental _____

Applicant/Member Name _____

Applicant/Member Identification # _____

Payor Bank Routing Number

Payor Account Number

Signature of Payor (Required)

Print Payor Name (Required)

Date

ALFA Health Plans
PO Box 1424
Columbia Tn 38402-1424
Fax 931-560-4278
Billingforms@fbhp.com