



Attn: CONNECTION Programs
 P.O. Box 400
 Independence, MO 64051-0400
 (800) 793-9335

4E

Date Received _____

Routing # _____

Account # _____

Prepared by: _____

Entered by: _____

Date: _____

Internal Use Only

BANK DRAFT AUTHORIZATION FORM

This form is required for monthly or quarterly Bank Draft. Bank Draft is available from a checking or savings account. We will contact your bank to set up the automatic draft for future payments.

INSTRUCTIONS: Please print in ballpoint pen or type. Complete this page in full, sign your name and date. Attach a blank check marked VOID in the space below. Mail to GEHA in the enclosed postage-paid envelope.

New plan enrollees: Please enclose a check or money order for your first premium payment along with your Enrollment Application. Make your checks payable to: GEHA CONNECTION Dental *Plus*.

MEMBER OR SURVIVOR ANNUITANT INFORMATION

GEHA ID CARD NUMBER OR SOCIAL SECURITY NUMBER OF FEDERAL EMPLOYEE _____

First Name	Middle Initial	Last Name	Daytime Phone ()
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SURVIVOR ANNUITANT PUT YOUR OWN SOCIAL SECURITY NUMBER HERE _____

BANK INFORMATION

Bank Name	Street Address		
City	State	ZIP	Daytime Phone ()

Select One Payment Option: **Bank Draft from Checking Account** **Bank Draft from Savings Account**
 Monthly Quarterly Monthly Quarterly

**ATTACH BLANK VOIDED CHECK
 OR
 SAVINGS ACCOUNT DEPOSIT SLIP HERE**

Verify with your banking institution the correct account number and routing number when using savings account option.

I authorize my bank listed above to pay and charge my bank account for checks drawn by and payable to the order of GEHA CONNECTION Dental *Plus* on a monthly or quarterly basis as indicated above. I understand that I will be charged in advance of the coverage month by automatic withdrawal. This authorization shall extend to any premium increase affected by the CONNECTION Dental *Plus* plan under the terms thereof.

Signature: _____ Date: _____



Open to *all* federal employees, *all* year long.

www.geha.com
(800) 793-9335