

# SURE PAY FORM

**AUTHORIZATION AGREEMENT FOR MONTHLY AUTOMATIC BANK PAYMENT**  
Please print in ink.

Name of Applicant or Policy Holder	Social Security Number
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Authorization to my bank:     Checking Account     Savings Account

I, (or we if a joint account) authorize the Oregon Medical Insurance Pool to charge my (our) checking account for monthly insurance premiums. I (we) authorize the financial institution named below to honor and pay these monthly charges. This authority is to remain in effect until revoked by me (us) in writing, and until you actually receive such notice, I (we) agree that you shall be fully protected in honoring any such check/draft. I (we) understand that in order to cancel these automatic deductions, I (we) must provide written notice to the Oregon Medical Insurance Pool no less than 15 days before the next scheduled automatic deduction.

**YOU MUST ATTACH A VOIDED CHECK WITH THIS AUTHORIZATION AGREEMENT**

**Note:** If this form is not completed and signed, premiums will be billed on a monthly direct bill basis. You must pay the billed premium until your bank processes this authorization or your coverage will be affected.

Financial Institution Transit/Routing Numbers	Account Number

Account Holder's Name (please print)

Account Holder's Authorized Signature(s) – as it appears on bank statement

Date

**Mail your completed authorization for monthly automatic bank payment to:**

Oregon Medical Insurance Pool  
PO Box 1271  
Mail Station 5K  
Portland, OR 97207-1271

**Attach Voided Check Here**