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**WASHINGTON STATE HEALTH INSURANCE POOL**

**BANK SERVICE PLAN  
AUTHORIZATION FORM**

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**TO: The financial institution named on the Request for Bank Service Plan – Authorization Form**

So that you may comply with your depositor's request, the Washington State Health Insurance Pool (WSHIP) agrees:

- a) To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, order or direction to debit an account purporting to be executed by WSHIP and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- b) In the event that any such check, draft, order or direction shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in forfeiture of insurance.
- c) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your action taken pursuant to the foregoing request or in any manner arising by reason of your participating in the foregoing plan of premium collection.



WASHINGTON STATE HEALTH  
INSURANCE POOL

**Washington State Health Insurance Pool • PO Box 1090 • Great Bend, KS 67530**



WASHINGTON STATE HEALTH  
INSURANCE POOL

**REQUEST FOR BANK SERVICE PLAN – AUTHORIZATION FORM (Optional)**

**For Monthly Premium Payments Only**

**TO: Washington State Health Insurance Pool**

Please use your Bank Service Plan to make my premium payments by withdrawing funds by automatic debit entry from the account below.

**WSHIP will withdraw from your account the first Friday of each month except when it falls on the 1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup>. In that case, we will then withdraw on the second Friday of the month. If you have any questions, call WSHIP Customer Service at 1-800-877-5187.**

\_\_\_\_\_  
Name as shown on Account Insured / Applicant

\_\_\_\_\_  
Insured / Applicant Identification Number (if you are a NEW Applicant, leave blank)

\_\_\_\_\_  
Name of Financial Institution Branch

\_\_\_\_\_  
City State ZIP

Transit/ABA No. \_\_\_\_\_ Account No. \_\_\_\_\_

***Please indicate below the type of account to be debited:***

Checking

Savings

As a convenience to me, I authorize WSHIP to pay and charge to my account automatic debit entries made upon my account by, and payable to, the order of Washington State Health Insurance Pool. I agree that WSHIP's rights with respect to each such charge will be the same as if it were personally executed by me. **This authorization is to remain in effect until WSHIP receives written notice from me to revoke it.** Any changes to your method of payment or automatic withdrawal, including bank information or termination of monthly bank draft, **must be submitted in writing by the 20<sup>th</sup> of the month** in order for the change to be implemented the first of the following month.

**X** \_\_\_\_\_ / / \_\_\_\_\_  
Authorized signature as shown on account Date

**ATTACH A VOIDED CHECK HERE:**

***Please return the Bank Service Plan to:***

Washington State Health Insurance Pool  
PO Box 1090  
Great Bend, KS 67530