

AUTHORIZATION TO HONOR BANK DRAFTS BY ProMedX

Policy Holder/Company Name _____

Primary cardholder ID or SSN _____

Type of Account: Checking Savings Other

Name of Bank _____

Name on Account _____

Bank Routing Number _____

Account Number _____

Please withdraw on the 1st of the month Please withdraw on the 15th of the month

I do hereby authorize ProMedX, LLC to draft this account, as listed above, for the purpose of paying ONLY the policy fees due to ProMedX, regardless of whether such Contract is listed in my name, my company name, or the name of some other person.

I hereby request and authorize you to pay and charge to my said bank account all drafts drawn by and payable to the order of ProMedX ONLY for this of this policy, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such draft shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect for 6 months for 50/20 policy or 1 year for 20/50 policy and then until revoked by me or ProMedX in writing after contract has ended; and until you actually receive such notice, I agree that you shall be fully protected in honoring any such draft.

I further agree that if after 6 months for 50/20 policy or 1 year for 20/50 policy, any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in the cancellation of the policy.

Policyholder's Signature



Please attach a voided check or savings deposit slip.

Please address all correspondence concerning Automatic Bank Draft to:

**ProMedX
Member Services
2912 Johnston Street
Lafayette, LA 70503**