



**AUTHORIZATION TO INITIATE BANK DRAFT**

**SONIC GROUP NUMBER(S) TO BE INCLUDED WITH THIS  
AUTOMATIC BANK DRAFT:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please return this completed from via fax to 816.391.1129 or to the following:

Sonic Health Plan  
P O Box 26725  
Kansas City MO 64196

**AUTHORIZATION TO HONOR DEBIT ENTRIES ORDERED BY  
THE SONIC HEALTH PLAN GROUP ADMINISTRATOR.**

As a convenience to me, I hereby request and authorize the SONIC HEALTH PLAN to initiate debit entries to my account on the behalf of Blue Cross Blue Shield of Oklahoma on or around the due date of the payment, provided there are sufficient funds in said account.

BANK ROUTING NUMBER \_\_\_\_\_

BANK ACCOUNT NUMBER \_\_\_\_\_

NAME ON BANK ACCOUNT \_\_\_\_\_

TYPE OF ACCOUNT     Checking     Savings

This authority is to remain in full force and effect until the SONIC HEALTH PLAN has received written notification from me of its termination in such time and in such manner as to afford it a reasonable opportunity to act.

Group Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_