



P. O. Box 33707, Indianapolis, IN 46203-0707

Dear Prospective Member:

Thank you for your interest in health care coverage offered by Kentucky Access.

In order to serve you effectively, please complete the checklist below prior to mailing your application. The checklist will ensure we receive all of the necessary information needed to process your application. If you have questions regarding any of the information referred to on the checklist or while completing the application, please contact our customer service department via e-mail at www.kentuckyaccess.com or by telephone at 1.866.405.6145.

- Is your application completely filled out and signed in black ink?
- Did you choose a health care plan (Traditional Access, Premier Access, or Preferred Access)? **See Section I.**
- Did you specify an effective date? If not, the effective date will be the first day of the month following the date the application was received. **See Section I.**
- If you have a post office box, is your current residency street address also included? **See Section II.**
- If you listed dependents, do they meet the eligibility requirements listed? Have you included proof of dependency? **See Section III.**
- Have you included proof of Kentucky residency (for at least 12 months)? If a driver's license is used as proof of residency, it must be issued at least 12 months prior to the date of your application. You do not have to meet the 12-month residency requirement if you are federally eligible under the HIPAA or currently enrolled in GAP. **See Section IV.**
- Did you check and initial an eligibility category? Did you include a copy of the documentation asked for under the category you checked? **See Section IV.**
- Did you identify any other health care coverage in effect? **See Section VI.**
- Have you individually listed all medical advice, care, prescriptions or treatment you received in the six months preceding your application? **See Section VII.**
- If the Pre-existing Waiver Benefit applied to you, did you include a certificate from your previous insurance carrier / employer? **See Section VIII.**
- Did you identify a premium payment cycle (Monthly, Monthly Bank Draft, Quarterly, Semi-Annual or Annual)? **See Section X.**
- Have you included the premium payment due according to the payment cycle chosen (monthly payment cycle requires an initial two months of premium)? **See Section X.**
- If you chose the Monthly Bank Draft premium payment cycle, did you complete and sign the Authorization Agreement for Automatic Withdrawal? Did you attach a voided check or a blank deposit ticket with all account information included? **See Section X.**
- Did you sign the Disclosure Authorization and Declaration? **See Section XI.**

APPLICATION FOR COVERAGE KENTUCKY ACCESS

P.O. Box 33707
Indianapolis, IN 46203-0707
1.866.405.6145
www.kentuckyaccess.com

Please type or print in black ink. All questions must be answered in complete detail (attach a separate piece of paper if necessary). If you have questions while completing the application, visit our web site at www.kentuckyaccess.com or call customer service at 1.866.405.6145.

SECTION I: PLAN INFORMATION	FOR OFFICE USE ONLY
	EFFECTIVE DATE OF COVERAGE: _____

I understand once eligibility is verified, the effective date of coverage will be the later of: 1) The first day of the month following the date application is received, or 2) the following date as requested (not to exceed three months after the month of application) _____.

<input type="checkbox"/> TRADITIONAL ACCESS (Fee for Service – FFS) <input type="checkbox"/> Single - \$400 <input type="checkbox"/> Family - \$800 <input type="checkbox"/> Mental Health Rider <input type="checkbox"/> Prescription Drug Rider	<input type="checkbox"/> PREMIER ACCESS (Preferred Provider Organization – PPO) <input type="checkbox"/> \$400 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$800 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> Mental Health Rider <input type="checkbox"/> Prescription Drug Rider	<input type="checkbox"/> PREFERRED ACCESS (Preferred Provider Organization – PPO) <input type="checkbox"/> Single <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> Family <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> Mental Health Rider <input type="checkbox"/> Prescription Drug Rider
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SECTION II: APPLICANT INFORMATION	E-MAIL ADDRESS (optional)
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B LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
HOME ADDRESS (Both Street and P.O. Box, if applicable)		SEX (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTH DATE: MONTH DAY YEAR AGE / / /
CITY	STATE	ZIP CODE	COUNTY OF RESIDENCE
HOME TELEPHONE () () ()	WORK TELEPHONE () () ()	CUSTODIAL PARENT / GUARDIAN IF APPLICANT IS MINOR	
NAME OF CURRENT EMPLOYER		START DATE AT CURRENT EMPLOYER	
NAME OF PREVIOUS EMPLOYER		BEGIN DATE OF PREVIOUS EMPLOYER	TERMINATION DATE OF PREVIOUS EMPLOYER
CHECK THE BOX BY YOUR TOTAL ANNUAL GROSS HOUSEHOLD INCOME:			
<input type="checkbox"/> \$0 - \$15,000 <input type="checkbox"/> \$ 25,001 - \$35,000 <input type="checkbox"/> \$45,001 - \$55,000 <input type="checkbox"/> \$65,001 - \$75,000 <input type="checkbox"/> \$15,001 - \$25,000 <input type="checkbox"/> \$ 35,001 - \$45,000 <input type="checkbox"/> \$55,001 - \$65,000 <input type="checkbox"/> \$75,001 or more			
HAVE YOU BEEN DETERMINED DISABLED BY SOCIAL SECURITY? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, The Date Determined Disabled Is _____ / _____ / _____ (Month / Day / Year) AND provide a copy of your determination letter			
HAVE YOU BEEN DETERMINED DISABLED BY THE MEDICAL REVIEW TEAM AT THE CABINET FOR HEALTH AND FAMILY SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, The Date Determined Disabled Is _____ / _____ / _____ (Month / Day / Year) AND provide a copy of your determination letter			

SECTION III: SPOUSE/DEPENDENT INFORMATION
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List spouse / dependents to be covered under this plan. Spouse and dependents must be a federally eligible individual or a resident for 12 months. In addition, a dependent must be: (1) unmarried and under the age of 19, (2) unmarried, under the age of 25, a full-time student at an accredited high school, trade school, college or university, and chiefly dependent upon you for support, OR (3) unmarried, incapable of self-sustaining employment by reason of mental or physical disability, and chiefly dependent upon you for support. A copy of the following for each dependent must accompany your application: 1) Proof of federal or state income tax records for the most recent twelve (12) month tax period, and 2) Letter of verification of full-time student status, or 3) Letter of determination of disability from the Social Security Administration.

C LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
RELATIONSHIP TO APPLICANT <input type="checkbox"/> Spouse <input type="checkbox"/> Child		FULL-TIME STUDENT <input type="checkbox"/> Yes <input type="checkbox"/> No	INCAPABLE OF SELF-SUSTAINING EMPLOYMENT <input type="checkbox"/> Yes <input type="checkbox"/> No Due To Mental or Physical Disability
		SEX (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTH DATE: MONTH DAY YEAR AGE / / /
D LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
RELATIONSHIP TO APPLICANT <input type="checkbox"/> Spouse <input type="checkbox"/> Child		FULL-TIME STUDENT <input type="checkbox"/> Yes <input type="checkbox"/> No	INCAPABLE OF SELF-SUSTAINING EMPLOYMENT <input type="checkbox"/> Yes <input type="checkbox"/> No Due To Mental or Physical Disability
		SEX (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTH DATE: MONTH DAY YEAR AGE / / /
E LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
RELATIONSHIP TO APPLICANT <input type="checkbox"/> Spouse <input type="checkbox"/> Child		FULL-TIME STUDENT <input type="checkbox"/> Yes <input type="checkbox"/> No	INCAPABLE OF SELF-SUSTAINING EMPLOYMENT <input type="checkbox"/> Yes <input type="checkbox"/> No Due To Mental or Physical Disability
		SEX (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTH DATE: MONTH DAY YEAR AGE / / /

SECTION IV: ELIGIBILITY INFORMATION

F Each Eligibility Category **REQUIRES ONE** of the following Documentary Proofs of Residency:

1) **PROOF OF CURRENT RESIDENCY** in the state of Kentucky, which may include one of the following documents: a receipt within 3 months prior to the date of application for rent, mortgage payment, utility bill, or a resident Kentucky income tax return for the most recent 12 month tax period, a copy of your active Kentucky driver's license OR a copy of your active Kentucky personal identification card issued by the clerk of the applicant's county of residence, or

2) **PROOF OF 12-MONTH RESIDENCY** in the state of Kentucky, which may include one of the following documents: a receipt 12 months prior to date of application **AND** another receipt within the last 3 months prior to the date of application for rent, mortgage payment, utility bill, or a resident Kentucky income tax return for the most recent 12 month tax period, a copy of your Kentucky driver's license issued at least 12 months ago **OR** a copy of your Kentucky personal identification card issued by the clerk of the applicant's county of residence dated 12 months or more prior to date of application for Kentucky Access.

PLEASE CHECK AND INITIAL EACH ELIGIBILITY CATEGORY DESCRIBED IN F-1 TO F-5 UNDER WHICH YOU ARE APPLYING

F-1 **FEDERALLY ELIGIBLE**

I am federally eligible according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 because I have had health care coverage for at least 18 months prior to the effective date of coverage with no lapse in coverage of at least 63 days. My most recent coverage was under a group plan and I have exhausted my benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA); I'm not eligible under another group health plan offered by my employer or as a dependent for coverage through my spouse, parent or guardian; My most recent coverage was not canceled because I failed to pay my premiums, or failed to pay my premiums in a timely manner, or committed fraud; I am not eligible for Medicare or Medicaid; and I did not accept a conversion policy or a short-term limited duration policy after my group, COBRA or state continuation coverage ended.

NOTE: If your employer failed to offer you benefits under COBRA, please indicate below. The fact that COBRA was never offered will not prevent you from being considered federally eligible under HIPAA.

Name of the employer that provided your last month of coverage: _____
 (Month / Day / Year)

The date you terminated from the employer that provided your last month of coverage: ____ / ____ / ____

Reason for termination of coverage:
 Failure to pay premiums For Fraudulent Reasons Other (Explain) _____

Did your former employer sponsor a health insurance plan for any of its employees? YES NO

Which of the following types of organizations was your former employer?
 Company Governmental Entity
 Church Other (Explain) _____

At the time you terminated employment with your former employer, did your former employer offer you an opportunity to continue your group insurance coverage (with you paying the premium) under COBRA or state continuation coverage? YES NO

Are you still employed by your current employer but your employer is terminating the group's coverage for all the employees? YES NO

Is your employer terminating your company's group coverage and offering to purchase individual policies for all of its employees? YES NO

During the past 21 months, have you accepted conversion or short-term limited duration coverage? YES NO

Does your spouse have group coverage with his or her employer? If YES, please explain why you will not be added to your spouse's coverage: _____ YES NO

Did you apply for individual insurance coverage with another insurance company prior to submitting this application to KY Access? YES NO
 If YES, was this application rejected? **Please enclose a copy of the rejection notice** YES NO
 Date you made application with this insurance company: _____

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) A copy of the Certificate of Health Plan Coverage or any other evidence of prior health insurance coverage provided by your previous insurance carrier / employer or other evidence of medical coverage. Examples of other types of documentation include letters from prior insurers and payment receipts.

2) **Proof of current residency** in the state of Kentucky for applicant listed in Section II and any persons listed in Section III, Spouse / Dependent Information. (See Section F for required documentation)

_____ **Initial Here**

F-2 **GUARANTEED ACCEPTANCE PROGRAM (GAP)**

I have previously received health insurance coverage under the Guaranteed Acceptance Program.

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) A copy of the notice verifying GAP enrollment from Anthem or Humana.

2) **Proof of current residency** in the state of Kentucky for applicant listed in Section II and any persons listed in Section III, Spouse / Dependent Information. (See Section F for required documentation)

_____ **Initial Here**

F-3 **REJECTION FOR HEALTH COVERAGE**
 I received notification of rejection from a health insurer for individual health coverage substantially similar to the coverage offered by Kentucky Access.
 Date your last health coverage ended: _____
 Date you made application with the insurer that issued the rejection: _____

If your health coverage ended within 90 days of the date of application, have you been offered a Conversion Policy? Yes No

REQUIRED DOCUMENTATION (Must Accompany This Application):
 1) A copy of the letter of rejection from the health insurer that is dated within 90 days of the effective date of Kentucky Access coverage.
 2) **Proof of 12-month residency** in the state of Kentucky for applicant listed in Section II and any persons listed in Section III, Spouse / Dependent Information. (See Section F for required documentation)

_____ **Initial Here**

F-4 **PREMIUM RATE HIGHER THAN KENTUCKY ACCESS**
 I received a premium rate for individual health insurance coverage substantially similar to the coverage offered by Kentucky Access either applied for or in force exceeding the premium rate for coverage by Kentucky Access.

REQUIRED DOCUMENTATION (Must Accompany This Application):
 1) A copy of the premium notice for the policy that is dated within 90 days of the effective date of Kentucky Access coverage.
 2) **Proof of 12-month residency** in the state of Kentucky for applicant listed in Section II and any persons listed in Section III, Spouse / Dependent Information. (See Section F for required documentation)

_____ **Initial Here**

F-5 **DIAGNOSED WITH A HIGH COST MEDICAL CONDITION**
 I have been diagnosed with one of the medical conditions listed below (please circle all conditions that apply).
 Date your last health coverage ended: _____
 If your health coverage ended within 90 days of the date of application, have you been offered a Conversion Policy? Yes No

Did you apply for individual insurance coverage with another insurance company prior to submitting this application to KY Access? YES NO
 If YES, was this application rejected? **Please enclose a copy of the rejection notice** YES NO
 Date you made application with this insurance company: _____

REQUIRED DOCUMENTATION (Must Accompany This Application):
 1) A letter from your physician stating your diagnosis of one of the medical conditions listed below.

AIDS	Juvenile Diabetes (Type I)	Quadriplegia
Angina Pectoris	Leukemia	Stroke
Ascites	Metastatic Cancer	Syringomyelia
Chemical Dependency	Motor or Sensory Aphasia	Wilson's Disease
Cirrhosis of the Liver	Multiple Sclerosis	Chronic Renal Failure
Coronary Insufficiency	Muscular Dystrophy	Malignant Neoplasm of the Trachea
Coronary Occlusion	Myasthenia Gravis	Malignant Neoplasm of the Bronchus
Cystic Fibrosis	Myotonia	Malignant Neoplasm of the Lung
Friedreich's Ataxia	Open Heart Surgery	Malignant Neoplasm of the Colon
Hemophilia	Parkinson's Disease	Short Gestation Period for a Newborn Child
Hodgkin Disease	Polycystic Kidney	Low Birth Weight of a Newborn Child
Huntington's Chorea	Psychotic Disorders	

_____ **Initial Here**

2) **Proof of 12-month residency** in the state of Kentucky for applicant listed in Section II and any persons listed in Section III, Spouse / Dependent Information. (See Section F for required documentation)

SECTION V: MEDICARE / MEDICAID COVERAGE

If any person named on this application is enrolled in Medicare or Medicaid, then that person would not be eligible for coverage through Kentucky Access.

G YES NO Is any person named on this application currently enrolled in **Medicare**?

YES NO Will any person named on this application be eligible for **Medicare** in the four-month period following date of application?
 If YES, name of person (s): _____
 Identification Number (s): _____
 Effective Date(s): Part A _____ Part A _____
 Part B: _____ Part B: _____

YES NO Are you currently eligible or will you be eligible in the future for premium-free Medicare Part A? If "NO", please tell us the amount of premium you pay for Medicare Part A only: _____

H YES NO Is any person named on this application currently enrolled in **Medicaid**?

YES NO Will any person named on this application be eligible for **Medicaid** on an ongoing basis following date of application?
 If YES, name of person (s): _____
 Identification Number (s): _____
 Effective Date(s): _____

SECTION VI: OTHER COVERAGE

YES NO Do you or any person named on this application have any other **medical** or **hospital** insurance?

If YES:

Name of person (s): _____

Insurance Company Name: _____

Insurance Company Phone: _____

TYPE OF COVERAGE:

Is your current coverage GROUP? YES NO
(Month / Day / Year)

The date you terminated or will be terminated from the company that is providing your group coverage: ____ / ____ / ____

Are you currently covered by COBRA or state continuation coverage? YES NO

If YES, and if you are approved for coverage with Kentucky Access, how many months will you have been on COBRA or state continuation coverage by the time you start coverage with Kentucky Access? _____

Is your current coverage INDIVIDUAL? YES NO

If YES, check the box that best describes your coverage:

Comprehensive Major Medical (CMM) Limited (e.g., "hospital-only" coverage or "cancer-only" coverage) Union plan

Professional or trade association plan Student health plan Another state health benefits risk pool (a plan like Kentucky Access)

Other (Explain): _____

Is it your intent to replace your current coverage with Kentucky Access coverage? YES NO

If YES, please explain the reason for replacement: _____

If NO:

Does your current employer offer health coverage to any of its employees? YES NO

If YES, has your employer offered you an opportunity to participate in the employer-sponsored health plan? YES NO

If YES, why aren't you participating in the employer-sponsored plan?

I have waived my employer-sponsored coverage

I've been directed to apply to Kentucky Access (please explain under "Other")

Other (Explain) _____

If you are married, is your spouse employed? YES NO

If YES, does your spouse's employer offer health insurance to its employees? YES NO

If YES, are you currently enrolled in your spouse's employer's plan? YES NO

If NO, why not? Missed enrollment Too expensive Spouse waived coverage Not available for dependents

Other, please explain: _____

YES NO Are you under age 18?

If YES, is your parent or guardian employed? YES NO

If YES, does their employer offer health insurance to its employees? YES NO

If YES, are you currently enrolled in your parent or guardian's employer's plan? YES NO

If NO, why not? Missed enrollment Too expensive Spouse waived coverage Not available for dependents

Other, please explain: _____

SECTION VII: PREMIUM PROVISION

J Will any **PART** or **ALL** of the premium used to purchase this coverage be provided by:

A church / church affiliated group? YES NO

A division of government, either county, city, state, federal or other? YES NO

A Government agency, such as Medicaid, Medicare, Public Health Department or other programs such as indigent programs? YES NO

A public or private foundation? YES NO

A health care provider? YES NO

An employer of the individual? YES NO

A person other than the individual's parent, adult child, or guardian? YES NO

Other (Explain) _____

If you answered "YES" to any questions above, please list the following:

Name of Organization: _____

Address of Organization: _____

Phone Number of Organization: _____

SECTION VIII: PRE-EXISTING CONDITIONS PROVISION

K Benefits under any Kentucky Access Plan (including spouse / dependent) will not be payable for a pre-existing condition (injury or sickness) for 12 months following the effective date of coverage if medical advice, diagnosis, care or treatment (including any prescription medications) for the pre-existing injury or sickness was recommended or received within a period of six months before the effective date of coverage. The 12-month period may be reduced by the number of months for which you have creditable coverage. A copy of the **Certificate of Health Plan Coverage** period by your previous health insurance carrier / employer or other evidence of medical coverage **must be sent along with this application.**

WAIVER BENEFIT: You and any person named on this application may be eligible for a waiver of the pre-existing condition waiting period if you are an eligible individual. A copy of the **Certificate of Health Plan Coverage** provided by your previous health insurance carrier / employer or other evidence of medical coverage **must be sent along with this application.**

PLEASE ANSWER THE FOLLOWING QUESTIONS

YES NO Have you or any person named on this application received medical advice, care or treatment including any prescription medications in the six months preceding the effective date of coverage.
If YES, please provide medical information for each person named on this application (attach an additional sheet of paper if necessary).

APPLICANT NAME	PHYSICIAN NAME	DIAGNOSIS	TREATMENT	DATES OF TREATMENT	DATES OF HOSPITALIZATION	MEDICATION	DATES BEGAN TAKING MEDICATION

SECTION IX: AGENT INFORMATION

If an insurance agent referred you to Kentucky Access, please fill out this section or have the agent fill out this section.
I certify by my signature that follows, that I have explained eligibility provisions to the applicant and assure that I have reviewed the application AFTER it was completed; the application is complete and accurate; and I have complied with KRS 304.17A-150 (3) [Unfair Trade Practices]

L	AGENT OR BROKER NAME			KENTUCKY INSURANCE LICENSE NO.			
	BUSINESS OR AGENCY NAME			SOCIAL SECURITY NUMBER OR TAX ID			
	ADDRESS			TELEPHONE NUMBER – WORK			
	CITY		STATE	ZIP CODE	TELEPHONE NUMBER – HOME (optional)		
	MAKE CHECK PAYABLE TO:						
	AGENT SIGNATURE:					DATE	

SECTION X: PREMIUM PAYMENT

M PLEASE CHOOSE ONE OF THE PREMIUM PAYMENT OPTIONS BELOW:

MONTHLY – 2 MONTHS PREMIUM DUE WITH APPLICATION.

VIA BANK DRAFT (Premium automatically deduct from your bank account). **Complete Authorization Form on following page.**

VIA MAIL (Premium bill sent via U.S. Mail).

QUARTERLY – 3 MONTHS PREMIUM DUE WITH APPLICATION.

SEMI-ANNUALLY – 6 MONTHS PREMIUM DUE WITH APPLICATION.

ANNUALLY – 12 MONTHS PREMIUM DUE WITH APPLICATION.

N USE THE PREMIUM RATE TABLE AND THE WORKSHEET BELOW TO DETERMINE YOUR PREMIUM PAYMENT:

AUTHORIZATION AGREEMENT FOR MONTHLY AUTOMATIC WITHDRAWAL OF INSURANCE PREMIUM

Kentucky Access offers a convenient payment option for members who are on a **monthly premium payment cycle**. Your premiums can be automatically withdrawn from your checking account on a monthly basis.

The withdrawal is done on the 1st Friday of each month in the bank's nightly cycle. (If the 1st Friday of the month falls on the 1st, 2nd, or 3rd day of the month, the withdrawal takes place on the 2nd Friday of the month).

To have your premium payment automatically withdrawn from your checking account each month:

1. Complete the **Authorization Agreement** below.
2. Verify your **Account Number** and **Routing Number** with your financial institution (frequently, the account number listed on your check includes digits that are not actually part of the account number).
3. Send a copy of a **Voided Check** or blank **Deposit Slip** with your application.

(detach here)

AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWAL



Member Identification Number: _____

I hereby request and authorize the Financial Institution named below to pay and charge to my account checks/drafts drawn on my account by and payable to the order of Kentucky State Treasurer provided there are sufficient collected funds in my account to pay such checks/drafts upon presentation. I agree that your rights in respect to each such check/draft shall be the same as if it were a check/draft drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check/draft.

I further agree that if any such check/draft is not honored, whether with or without cause and whether intentionally or inadvertently, you shall have no liability whatsoever even though such action results in forfeiture of medical insurance coverage. This authorization is to remain in effect until you receive 15 days written notice from me of its revocation.

BANKING INFORMATION

NAME OF INSURED (APPLICANT)		NAME OF JOINT ACCOUNT HOLDER	
NAME OF FINANCIAL INSTITUTION		TYPE OF ACCOUNT <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
FINANCIAL INSTITUTION ADDRESS		ACCOUNT NUMBER	
CITY	STATE	ZIP CODE	ROUTING NUMBER

SIGNATURE OF ACCOUNT HOLDER(S)

NAME OF ACCOUNT HOLDER (please print)		NAME OF JOINT ACCOUNT HOLDER (please print)	
SIGNATURE	DATE (mm / dd / yy) / /	SIGNATURE	DATE (mm / dd / yy) / /

TO FINANCIAL INSTITUTION: In consideration of your honoring pre-authorized checks/drafts drawn against depositors of your financial institution for the payment of amounts to the Kentucky State Treasurer, we agree that no liability or responsibility shall attach to your financial institution as a result of honoring or not honoring such checks/drafts, and we further agree to hold you harmless from and reimburse you for any loss resulting as a consequence of your actions taken pursuant to your agreement to honor such checks/drafts. We shall defend any action brought against you by any of your depositors or any other person because of your compliance with the pre-authorized check/draft plan.