

Payment Authorization Form

General Information

Policyholder Name			Policyholder Number		
Address			Contact Phone		
City	State	Zip			

Method of Payment (select one) – Please print legibly.

<p>BANK ACCOUNT DEBIT (ACH)</p> <p><input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account</p> <p><i>You may provide a copy of a voided check or deposit slip for purposes of verifying your account data.</i></p>			<p>CREDIT/DEBIT CARD</p> <p><input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover</p>		
Routing Number			Name on Card		
Account Number			Card Number		Expiration Date (MMYY)

Authorization Agreement

I authorize Security Life to initiate electronic debits to the account listed above for payment of my insurance premium. I certify that I am an authorized user on the above listed account. I acknowledge that debits to my account for premium due will occur on a regular recurring basis based on the payment frequency previously selected until such time as coverage terminates or until I notify Security Life to terminate these transactions. Based upon my authorization Security Life will debit my account for any current and outstanding due premiums on or within three business days following my premium due date. For initial payments I acknowledge that Security Life may debit my account upon acceptance and approval of my application.

If any authorized payment is returned or dishonored by my bank, I acknowledge that I am responsible for any fees my bank may charge. I understand also that I may incur a return payment fee of \$25 charged by Security Life if the return is due to insufficient funds. Such a fee, if charged, may be automatically debited from my authorized account on the next payment date. I am responsible for remitting payment within the policy grace period. If payment is not received by Security Life within the defined grace period I acknowledge that my coverage may be cancelled in accordance with the terms of the insurance contract.

I understand that it may take up to two weeks to process a request to discontinue recurring payments. In order to make changes to this authorization (such as change in bank account, method of payment, or termination of payment) I must provide Security Life at least two weeks' notice in advance of the next scheduled payment date.

I acknowledge that the origination of these electronic transactions (ACH and Card) must comply with applicable provisions of US Law.

Signature

Authorized Signature _____ Date _____

Return form to:

<p>FAX 717.481.7175</p>	<p>MAIL Security Life Insurance Company of America P.O. Box 10095 Lancaster, PA 17608</p>
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For Company use Only: Effective Date of Change