

Senior Health Insurance Company of Pennsylvania

Primerica Life Insurance Company

American Health & Life Insurance Company

Stonebridge Life Insurance Company

Senior Health Insurance Company of Pennsylvania Bank Draft Authorization

Policyholder Name: _____

Policy Number: _____

Circle frequency of payment: MONTHLY QUARTERLY SEMI-ANNUAL ANNUAL

Circle type of financial institution: BANK Credit UNION

Circle type of account: CHECKING¹ SAVINGS²

Elect Withdrawal Day³: _____

¹ Attach a voided check – deposit slips are not acceptable ² Verify Routing Number and Account Number with Bank/Credit Union prior to submitting ³ This is the day your payment will be withdrawn from your account according to the frequency indicated above. Choose any day from the 1st through the 28th.

Bank Transit/Routing Number Account Number: _____

Name of Bank/Credit Union: _____

Address of Bank/Credit Union City State Zip Code: _____

AUTHORIZATION FOR BANK DRAFT TO PAY INSURANCE PREMIUM

As a convenience to me, I hereby request and authorize Senior Health Insurance Company of Pennsylvania (SHIP), home office Bensalem, PA, to make withdrawals from the account stated above including checks, drafts or electronic fund transfers, payable to SHIP, pursuant to the instructions set forth above for the purpose of paying premiums for the insurance policy stated above. I understand: 1) debits made hereunder shall be the same as if they were pursuant to a check payable to SHIP and signed by me; 2) the debit reflected on my bank/credit union statement shall constitute a receipt of my payment; 3) SHIP shall have no obligation to notify me if any account withdrawal is not paid upon presentation; 4) if any payment is not made by me for any reason, with or without cause, SHIP shall be under no liability whatsoever even though such nonpayment may result in the forfeiture of insurance, and 5) this authorization shall not be construed as a modification of any of the provisions of the above stated insurance policy. This authorization shall remain in full force and effect until revoked in writing upon thirty (30) days notice by and to either party.

Policyholder printed name: _____

Policyholder Signature: _____

Date: _____

RETURN COMPLETED FORM TO:

Senior Health Ins. Co. of Pennsylvania
P.O. Box 64913, St. Paul, MN 55164

or fax to 952-983-5256