

Please write legible. All fields are required.

## Information from the Policy Holder

Policy Holder's Name		Person ID Number
Payer's Name		Payer's Person ID Number
Address		ZIP Code
Phone Number	E-Mail	

**New Payment Method**

EFT Payment (ACH)     Credit Card

Frequency    Monthly     Quarterly     Semi Annual     Annual

## Bank information

<input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	Account number:	ABA routing number:
Name of Financial Institution:		

<input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express	Card number:	Security Code (CVC):
Expiration date: <span style="margin-left: 20px;">MM/AAAA</span>	Name on the card:	

I hereby state that all the answers and statements contained herein are complete in details and are true.	Signed in
	Date <span style="margin-left: 20px;">MM / DD / YYYY</span>

**IMPORTANT NOTICE**

Any person who knowingly and with the intention of damaging, committing fraud or deceiving an insurer submits a claim or request that contains false, incomplete or misleading information is guilty of a third degree felony.

Policy Holder's Signature	Payer's Signature
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FOR OFFICE USE ONLY

Processed by: \_\_\_\_\_ Date: \_\_\_\_\_