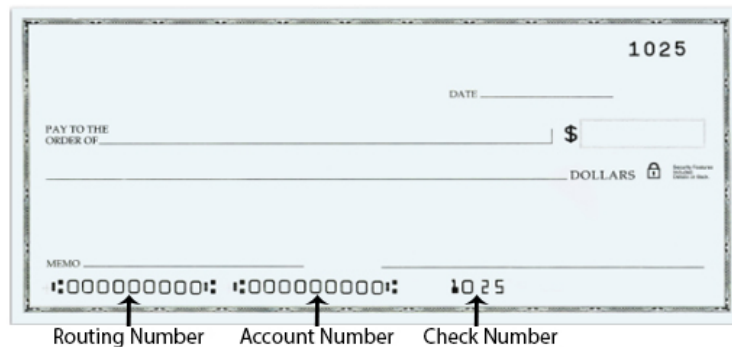




## Local Government Health Insurance Plan Pre-Authorized Payment Service Authorization Agreement

I authorize Local Gov Health and Wellness and the financial institution, listed below, to electronically debit or credit my account as specified:

|                                 |
|---------------------------------|
| Name of Financial Institution   |
| Routing Transit Number          |
| Checking/Savings Account Number |



This authority is to remain in full force and effect until Local Gov and my financial institution have received written notification from me of its termination. This should be done in such time and manner as to afford Local Gov and the financial institution a reasonable opportunity to act on it.

### SUBSCRIBER INFORMATION

### ACCOUNT HOLDER INFORMATION

|                                         |                                           |
|-----------------------------------------|-------------------------------------------|
| <b>Contract Number</b>                  |                                           |
| <b>Subscriber's Name (please print)</b> | <b>Account Holder Name (please print)</b> |
|                                         |                                           |
| <b>Subscriber's Signature</b>           | <b>Account Holder Signature</b>           |
| <b>Date</b>                             | <b>Date</b>                               |

Please include your voided check with this form to verify account information for withdrawals from your checking account or a deposit slip for withdrawals from a savings account. Form may be returned with your payment.

Return this form to:  
Local Gov Health and Wellness  
Accounting Department  
PO Box 304901  
Montgomery, AL 36130  
[accounting@lghip.org](mailto:accounting@lghip.org)