



ACH Payment Processing Form

This form authorizes SafeGuard Wisconsin to automatically deduct your monthly payment* on the 1st of each month. Please complete this form and return it along with a voided check from the bank account where funds will be withdrawn.

**No funds will be withdrawn until the excess loss insurance policy is issued.*

Employer Information

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Name on Account (Account Holder) Phone Number

Address

City State

Email Address Zip Code

Financial Institution Information

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Name (Financial Institution) Phone Number

Address

City State Zip Code

PLEASE ATTACH VOIDED CHECK		
Please select one:		
<input type="checkbox"/> Checking <input type="checkbox"/> Savings		
Bank Routing Number		
Bank Account Number		

I authorize SafeGuard Wisconsin to obtain payment of my monthly payment by initiating charges to my account in the form of electronic debit entries. I authorize the Financial Institution listed above to accept and honor the SafeGuard Wisconsin initiated electronic debit entry and to charge the account provided above. This authorization will remain in effect until I notify SafeGuard Wisconsin in writing that I have terminated this authorization. I agree to allow at least 7 business days for SafeGuard Wisconsin to act on the termination. I acknowledge receiving a copy of this authorization on this date.

Authorized Signature _____ **Date** _____

Excess loss insurance policies and EPO/PPO insurance plans underwritten by US Health and Life Insurance Company. SafeGuard plans administered by US Health and Life Insurance Company. © US Health and Life Insurance Company. All rights reserved.