



Central States Health & Life Co. of Omaha
 Medicare Supplement Administration
 PO Box 10844
 Clearwater, FL 33757-8844

Office: 1-833-522-4874 (toll-free)
 Fax: 1-855-255-8653
 Online: www.CSOMedSupp.com

ELECTRONIC PAYMENT AUTHORIZATION FORM

Insured Name: _____ Insurance Policy Number: _____

Sign and date this authorization below

As a convenience to me, I hereby request and authorize you to pay and charge to my bank account checks drawn by and payable to the order of Central States Health & Life Co. of Omaha, provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of Central States Health & Life Co. of Omaha to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn by you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Please indicate below when you would like your account drafted. Many of our customers have requested the option to pay their premiums on the same day they receive Social Security or SSI payments. The options below allow you to select the date that best fits your needs. You may select any option regardless of whether or not you receive Social Security.

Section 1 – Select one of the following date options.

Initial Premium Payment: (choose one)	<input type="checkbox"/> Same as subsequent payment date selected below, on or after the requested Effective Date <input type="checkbox"/> On the Policy Issue Date <input type="checkbox"/> Paid by enclosed check		
Subsequent Premium Payments: (choose one)	<input type="checkbox"/> 1 st day of the Month <input type="checkbox"/> 3 rd day of the Month	<input type="checkbox"/> 2 nd Wednesday of the Month <input type="checkbox"/> 3 rd Wednesday of the Month <input type="checkbox"/> 4 th Wednesday of the Month	
NOTE: If one of the <u>above</u> dates falls on a weekend or holiday, deduction will be on prior business day. <input type="checkbox"/> Other, please specify a day of the month from 1 to 28 _____ (if this date falls on a weekend or holiday, deduction will be on next business day)			

Section 2 – Select one of the payment options.

<input type="checkbox"/> Checking (Attach voided check)	<input type="checkbox"/> Savings
Branch/Bank Name: _____	
Routing Number: _____	Account Number: _____

Section 3 – Complete name and address as shown on account.

Accountholder Name: _____

Address/City/State/Zip: _____

Section 4 – Please sign and date.

Signature: _____ Date: _____