

Illinois Life & Health Insurance Guaranty Association PO Box 4198 Lisle, IL 60532 Tel. (773) 444-4071 Fax. (773) 304-3559

ILClaims@illinoisga.org

Pr	emium Payme	nt ACH	Aut	horiza	tion	Form	
Policy Owner's Name Policy Owner's Address				Po	olicy# (rec	quired)	
Policy Owner's Phone	Policy Owner's Email						
Premius	n Payments via A	CH Frequ	ıency.	-Select 1 o	f the be	elow options	
No Change - Keep	current billing frequency	(5% discount w	vill only a	pply for first tim	e monthly	ACH setup)	
Change payment frequ	ency to:						
Monthly (5% discount	will only apply for first time A	.CH set up)		Quarterl	у	Semi-Annually	Annually
	Bank Account In	formation	(Chec	king Acco	unts Or	nly)	
Bank Account Owner's Name	<u> </u>						
What is your relationship to	olicy Owner?		Self	Other			
Complete all the information	tion in this section a	nd attach a	void	check (requi	ired)		
Bank Account Owner's Addr					-		
Financial Institution's Name							
ABA Routing Number (9 digits Checking Account Number	located on bottom left of chec	ck)					
By signing this form,	understand and a	ccept thes	se terr	ns and con	ditions	:	
The selected payment method	does not alter or change	the policy prov	visions.				
I hereby authorize and reques	that ILHIGA draft my acc	count as noted	above.				
ILHIGA will only consider a pr	emium paid if a draft is ho	onored by my f	financial	institution.			
If two ACH payments are retu period of twelve months on di					e changed	d to quarterly direct	billing. After a
In the event that the payment	method is changed to dire	ct billing, the b	oilling no	tices will be se	nt to the F	ayor on record.	
I must notify ILHIGA in writin I must provide a current addre			duled wi	thdrawal to cha	ange or ca	ncel this authorizat	ion. In addition,
I understand that for monthly	drafts, the initial draft will	include any pa	ast due p	remiums requi	red to brin	g my policy curren	t.
Bank Account Owner's Sig	nature					Date	
Policy Owner's Signature (If other than Bank Account O	 wner)					Date	