



Illinois Life and Health Insurance Guaranty Association  
 PO Box 4198  
 Lisle, IL 60532  
 www.ilhiga.org

## ACH Authorization Form

tel. 773.444.4071  
 fax. 773.304.3559  
 ILClaims@illinoisga.org

Policyholder Name \_\_\_\_\_ Policy Number Required \_\_\_\_\_

Policyholder Address \_\_\_\_\_

Policyholder Phone \_\_\_\_\_ Policyholder Email Address \_\_\_\_\_

### Premium Payments

Use this section to **select your payment frequency** for your premium withdrawals. If no selection is made, withdrawals will be monthly

Monthly       Quarterly       Semi-Annually       Annually

### Bank Account Information (Checking Accounts Only - Please attach a void check)

Please Print Clearly

Bank Account Owner's Name \_\_\_\_\_

What is your relationship to Policy Owner?     Self     Other

Please **attach a void check** and complete all information in this section.

Bank Account Owner's Address \_\_\_\_\_

Financial Institution's Name \_\_\_\_\_

ABA Routing Number (Typically 9 digits and located on bottom left of check) \_\_\_\_\_

### Authorization

Checking Account Number \_\_\_\_\_

By signing this form, I understand and accept these terms and conditions:

- The selected payment method does not alter or change the policy provisions.
- I hereby authorize and request that ILHIGA draft my account as noted above.
- ILHIGA will only consider a premium paid if a draft is honored by my financial institution.
- If two ACH payments are returned within a twelve-month period, your payment method will be changed to quarterly direct billing. After a period of twelve months on direct billing, you may re-apply for an ACH option.
- In the event that the payment method is changed to direct billing, the billing notices will be sent to the Payor on record.
- I must notify ILHIGA in writing at least 10 business days before a scheduled withdrawal to change or cancel this authorization. In addition, I must provide a current address for future billing notices.
- I understand that for monthly drafts, the initial draft will include any past due premiums required to bring my policy current.

Bank Account Owner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Policy Owner's Signature (If other than Bank Account Owner) \_\_\_\_\_ Date \_\_\_\_\_