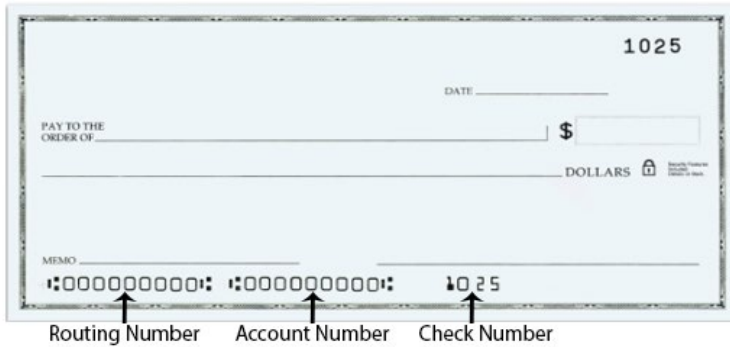


# Local Government Health Insurance Plan Pre-Authorized Payment Service Authorization Agreement

I authorize the Local Government Health Insurance Board (LGHIB) 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 LGHIB 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 LGHIB and the financial institution a reasonable opportunity to act on it.

UNIT INFORMATION	ACCOUNT HOLDER INFORMATION
<b>Subscriber's Number</b>	
<b>Subscriber's Name (please print)</b>	<b>Account Holder Name (please print)</b>
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <p style="text-align: center;"><b>Subscriber's Signature</b></p> <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/> <p style="text-align: center;"><b>Date</b></p>	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <p style="text-align: center;"><b>Account Holder Signature</b></p> <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/> <p style="text-align: center;"><b>Date</b></p>

Please staple your voided check to 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 Government Health Insurance Board**  
**Accounting Department**  
**PO Box 304900**  
**Montgomery, AL 36130-4900**  
[accounting@lghip.org](mailto:accounting@lghip.org)