

Assurant Health
 501 W. Michigan
 P.O. Box 2948
 Milwaukee, WI 53201-2948

Fax completed authorization to 414.299.8906

Policyholder Name: _____
(Last) (First) (M.I.)

Policy Number(s): _____

Payment Method Change to:

Monthly

- EFT
 Credit Card

Quarterly

- Direct Bill
 EFT
 Credit Card

Semi-Annual

- Direct Bill
 EFT
 Credit Card

Annual

- Direct Bill
 EFT
 Credit Card

Please complete the appropriate Authorization below based on the payment method you selected.

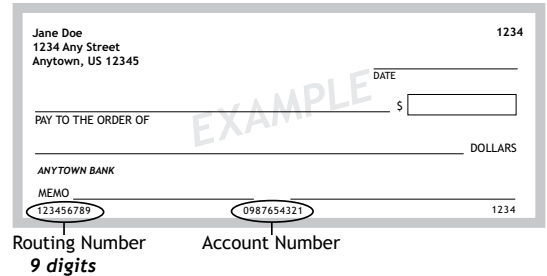
Electronic Funds Transfer (EFT)/Check-O-Matic

- To begin EFT/Check-O-Matic withdrawals:
 Select a desired withdrawal day 1-28:

Bank Name: _____
 City: _____ State: _____
 Routing number: _____
 Account number: _____

- To add this policy to an existing EFT/Check-O-Matic:

Existing EFT/COM Number: _____
 Associated Policy Number: _____



AUTHORIZATION FOR EFT/CHECK-O-MATIC BILLING – please sign below

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated above, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder Signature: _____ Date: _____

Credit card

AUTHORIZATION FOR CREDIT CARD PAYMENTS – please sign below

I authorize Time Insurance Company to charge my account for the individual supplemental insurance policy.

Card number: _____ - _____ - _____ - _____

Card type: VISA MasterCard

Expiration date: ____/____

Name as it appears on card: _____

Cardholder billing address if different than resident address: _____

Cardholder signature: _____ Date: _____

Bill me directly

If your billing address is different than your home address, please enter it here:

Billing Address: _____
(Street) (City) (State) (ZIP)

Name of person paying, if different than policyholder: _____