

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

I authorize Benefits Store, Inc. to initiate periodic deductions from my account shown below.

<p><u>ATTACH YOUR PREMIUM CHECK HERE!!!</u></p>
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I understand this authority is to remain in full force and effect until Benefits Store, Inc. has received a written notification from me of its termination in such time and such manner as to afford the company and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by notification to Benefits Store, Inc. twenty (20) business days or more before this payment is scheduled to be made.

Choice of Payment Dates – [] 5th or [] 15th of each Month

A \$5.00 Service Charge may be added for any item returned by the bank.

Signature of Depositor _____ Date _____

For Benefits Store, Inc. Use Only

Account Information

Policy Holder Name: _____

Policy Number _____

Deduction Amount \$ _____

Once a Month beginning on the 5th/15th day of _____

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