

Employer Authorization Agreement for Automatic Payment

To be completed by employer

BANK INFORMATION

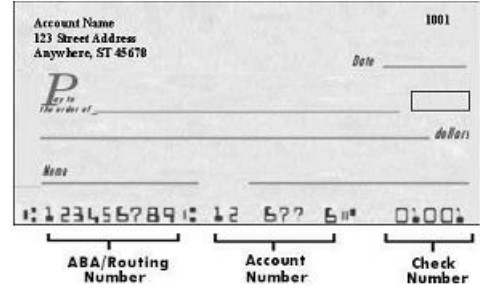
Bank name: _____ Phone number: (____) _____

City: _____ State: _____ ZIP Code: _____

Routing number (9 digits) _____

Account number: _____

Select only one: checking account saving account



EMPLOYER AUTHORIZATION

- I hereby authorize THE CHRISTIAN AND MISSIONARY ALLIANCE to withdraw funds each month from this account for payment of insurance premiums.
- I understand this authority is to remain in full force and effect until ALLIANCE BENEFITS has received written notification from my/our authorized representative of its termination in such manner as to afford THE CHRISTIAN AND MISSIONARY ALLIANCE and my bank a reasonable opportunity to act on it.

Name of account holder as printed on check: _____

Signature of authorized employer representative: _____ Date: ____/____/____

Title: _____ Contact phone: (____) _____ E-mail: _____

Attach a cancelled check and return completed form to: Alliance Benefits
PO Box 35690
Colorado Springs, CO 80935-3569

Or fax this form and a copy of voided check to: 719-262-5397

<p style="text-align: center;">For Office Use Only</p> <p><input type="checkbox"/> Startup Request</p> <p><input type="checkbox"/> Change Request</p> <p>Date change is effective: _____</p>

For more information or eligibility rules go to www.alliancebenefits.org

