

Payment Authorization Form



Primary applicant name:	Requested effective date:
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Payment Frequency

Payment Type	
<input type="checkbox"/> Automatic Credit card payment <i>(If elected, complete Section A and sign and date Section C)</i>	<input type="checkbox"/> Automatic bank draft/ACH payment <i>(If elected, complete Section B and sign and date Section C)</i>

A. Automatic credit card payment information and authorization	
Card type <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Discover	Name—as it appears on the card
Card Number	Expiration date

B. Automatic bank draft/ACH payment information and authorization	
Account type <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Account holder name
Name of bank	Relationship to proposed insured
Routing number (from your check as shown below)	Account number (from your check as shown below)

Jane Doe 2139 S. 33 St. AnyTown, USA 12345	Date: _____	1234
PAY TO THE ORDER OF _____	\$ _____	
		DOLLARS
Bank Name		
Memo _____		
(Routing #)	(Account #)	

C. Signatures
I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the Ebix Health Administration Exchange, Inc. or its designated administrator in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that the Ebix Health Administration Exchange, Inc. or its designated administrator may at its discretion attempt to process the charge again within 30 days, and agree to an additional \$25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this recurring billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.

<u> X </u>	_____
Signature of account holder	Date