

Pre-Authorized Check (PAC) Draft Authorization

Return this form by:

Email: adminservices@gilsbar.com * **Fax:** 985-871-1855

Mail: Gilsbar L.L.C. Attn: Administration Dept., P.O. Box 998, Covington, LA 70434

Request for Monthly Payment of Premiums by Automatic Bank Deduction

As a convenience to me, I authorize **Gilsbar, L.L.C., Covington, LA (TIN #72-0519951)** to debit premiums and, if necessary, make adjustments for any error to my account at the Bank (or other financial institution) I have indicated below. I also authorize said Bank to debit and, if applicable, credit the amount of those entries to my account made payable to the order of **Gilsbar, L.L.C., Covington, Louisiana.**

I understand and agree that:

- 1) My premium will be drafted the 5th day of each month or the next business day thereafter;
- 2) The Bank's rights with respect to each charge will be the same as if personally executed by me;
- 3) This authorization will remain in effect until I provide written notification to Gilsbar, L.L.C. that I wish to revoke it. I will allow Gilsbar, L.L.C. thirty (30) days to act on this notice;
- 4) Gilsbar, L.L.C. and my Bank may discontinue this service; and
- 5) The presentation of any such debit or draft shall constitute due notice of premiums being due for a policy of insurance on my behalf and/or on behalf of my eligible dependents. I understand that should my Bank dishonor any such debit or draft for any reason, it will be my responsibility to make arrangements with Gilsbar, L.L.C. for premium payments within the grace period to prevent lapse or possible termination due to nonpayment in accordance with the terms of the policy. It is also understood that Gilsbar assumes no responsibility for bank charges on these draws.
- 6) I further agree that my bank shall be under no obligation to furnish me with any special advice or notice of the payment of any such debit, other than my monthly banking statement.
- 7) I will keep a copy for my records.

INSURED INFORMATION (premium payor)

(Please print in ink or type)

Name of Insured/Employer

Name of Professional Membership Affiliation

Certificate Holder ID (SSN)

Month to Begin My PAC Service

Daytime Telephone Number

BANK ACCOUNT INFORMATION

Name of Bank or Financial Institution

Branch City State Zip

Name(s) as Appears on Bank Account

Please circle one: Checking ~~Savings~~

Account Number

Bank Transit/Routing Encoding #

Signature* of Premium Payor

DATE

(Must be identical to bank records)

***Signature of Account Holder(s)**

DATE

(If joint account, both signatures required)



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