



DEBIT AUTHORIZATION

I authorize **Allegiance Life & Health Insurance Company, Inc.** and the Financial Institution listed below to initiate electronic withdrawal from our account for the monthly premium charges for our policy with the effective beginning date (mm/dd/yy) _____, issued by Allegiance Life & Health Insurance Company, Inc. to the below undersigned Company (“Company”).

The monthly withdrawal amount will be communicated to Company in accordance with the Policy.

The authorization is to remain in full force and effect until Allegiance Life & Health Insurance Company, Inc., has received written notification from our Company (“Company”) of its termination of this policy in such time and in such manner as to afford Allegiance Life & Health Insurance Company, Inc., and its Bank or other depository, a reasonable opportunity to act upon such termination.

All notices and communications to Company will be to the following:

- Checking (attach a voided check) Savings (attach a withdrawal slip)

Legal Company Name	
Address	City, State, Zip
Authorized Contact’s Name (please print)	Alternate Contact (if applicable)
Email Address	Financial Institution Name
Phone Number	Routing/Transit Number
Fax Number	Account Number
Authorized Contact’s Signature	Date

On behalf of the Company, I understand that Allegiance Life & Health Insurance Company, Inc., may initiate a reversal of any entry made under this agreement if an error has been made. I understand that the financial institution at which I have the above account is required to provide to me the procedures for resolving errors on entries made under this Debt Authorization agreement. I understand that Allegiance Life & Health Insurance Company, Inc., will provide a written notice to me of the error within 24 hours.

Authorized Contact’s Initials

Allegiance Life & Health Insurance Company, Inc.
P.O. Box 3507
Missoula, MT 59806
1-800-737-3137