



Payment Authorization Agreement – Enhanced Billing Solution

Certificate Holder/Applicant Information

Group Number: <u>APFA #25047</u>	Certificate Numbers	Premium Amount	Certificate Numbers	Premium Amount
Name: _____	_____	_____	_____	_____
Address: _____	_____	_____	_____	_____
City, State, ZIP: _____	_____	_____	_____	_____
Phone: _____	No. of certificates:	<input type="text"/>	Total: \$	_____
Email address: _____				

Deduction Information

For newly issued certificate only: For ease of your coverage administration, if the certificate is issued, we will make the effective date coverage the same as your selected draft date following the receipt of your application in the home office.
 Applicant's Initials _____

What is the deduction frequency of the Group (Please choose one)?

Weekly Bi-Weekly Semi-Monthly Monthly Quarterly Semiannually Annually

Please provide the deduction day of the week: Monday Tuesday Wednesday Thursday Friday

Please provide the date of first deduction. _____

I choose to pay by electronic draft.

Account Holder's Name: _____
 Account Holder's Address: _____
 City: _____ State: _____ ZIP: _____
 Transit/ABA Number: _____
 Account Number: _____ Checking Savings

I choose to pay by credit or debit card (only Visa, MasterCard, and American Express are accepted).

Card Holder's Name: _____
 Card Holder's Address: _____ City: _____ State: _____ ZIP: _____
 Card Number: _____ Expiration Date: _____ CVV Code (back of card): _____

Confirmation / Authorization

I hereby authorize Continental American Insurance Company ("Company") to initiate debit entries to the deposit account designated above, at the financial institution ("Financial Institution") named above, using the Automated Clearing House ("ACH") or other payment transfer service chosen by Company from time to time. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until Company has received written notification from me of its termination in such time and in such manner as to afford Company and the Financial Institution a reasonable opportunity to act on it. I represent that (i) the credit or debit card ("Card") information provided above is accurate; and (ii) that I own the account (or have legal authority to use the account) being accessed by the Card provided. I understand and agree that Aflac will continue to initiate recurring debit entries or charges to the Card account beyond the expiration date of the Card and will automatically update the Card information as necessary to continue initiating debit entries or charges.

Account Holder's/Card Holder's Signature: _____ Date: _____
 (If different from Certificate Holder/Applicant)

Certificate Holder's/Applicant's Signature: _____ Date: _____

Agent's Signature: _____ Writing Number: _____ Date: _____
 (Required if agent assisting with application)

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