



Equity-League Health Insurance Premium Opt-Out Form

AUTHORIZATION DETAILS

ActorsFCU Account Number: _____

ActorsFCU Account Type: Power Checking (Draft)

ActorsFCU Account Name: _____

AEA Member Number: _____

AEA Member Name: _____

OPT OUT AUTHORIZATION

This will certify that I wish to Opt Out of ActorsFCU's automated Equity-League Health Premium payments. I understand that by exercising this option, it will be my responsibility to pay all future premiums as they become due. This is effective upon submission.

SIGNATURE

Member Signature

Date