



Equity-League Health Insurance Premium ACH Authorization

AUTHORIZATION DETAILS

ActorsFCU Account Number: _____

ActorsFCU Account Type: Power Checking (Draft)

ActorsFCU Account Name: _____

AEA Member Number: _____

AEA Member Name: _____

AUTOMATIC DEDUCTION AUTHORIZATION

By signing below I agree to the Courtesy Pay Authorization. I authorize ActorsFCU to deduct my Equity-League Health Premiums from my ActorsFCU Power Checking account in the amount billed by Equity-League Pension and Health and to transfer the amount to Equity-League Pension and Health. I understand that the deduction from my account will occur approximately the first of the month prior to the start of coverage. This will happen in the months of March, June, September, and December for quarterly payments. I hereby certify that all information on this application is true and complete to the best of my knowledge. I accept the terms of the agreement and other terms as may be determined by ActorsFCU from time to time.

COURTESY PAY AUTHORIZATION

If the funds in my ActorsFCU Power Checking account are unavailable or insufficient to pay the above quarterly total, I understand and authorize ActorsFCU to pay my health insurance premium(s) using the Courtesy Pay program. I understand that Courtesy Pay will only be used should the funds in my ActorsFCU Power Checking account be unavailable or insufficient to cover the premium(s) selected above, up to the maximum Courtesy Pay limit. Your available Courtesy Pay availability may be reduced by recent overdrafts. If I have established other overdraft protection methods, such as a line of credit or automatic transfer from my other ActorsFCU accounts, I understand that ActorsFCU will always look to pay any insufficiency by those other methods first before using Courtesy Pay and imposing a fee.

SIGNATURE

Applicant Signature: _____ Date: _____