AULTCARE

Direct Withdrawal Authorization Form

Individual Insurance Premiums

I authorize AultCare Insurance Company to initiate an electronic draw of monthly premium deductions from my account listed below. This change is to be effective as of _____ (month/day/year). I understand I must maintain sufficient funds in my designated account to cover the total the Automated Clearing House (ACH) amount or my policy will lapse for non-payment of premium. This authorization will remain in effect until AultCare and my financial institution have received written notification of termination from me *(allow 7-10 business days for deductions to cease).*

Premiums are to be deducted from: ☐Checking ☐Savings (check one)
(Please note: Not all financial institutions allow deductions from a savings account. Please verify this with your financial institution.)

NAME OF FINANCIAL INSTITUTION | CITY | STATE

APPLICANT'S NAME (PLEASE PRINT) | PHONE NUMBER | MEMBER ID#

APPLICANT'S SIGNATURE | DATE

ACCOUNT HOLDER NAME (IF DIFFERENT FROM APPLICANT)

ACCOUNT HOLDER'S SIGNATURE | PHONE NUMBER | DATE

A voided check or voided check image is required when submitting this form. You may return this form via US Mail or electronically.

Physical forms with a **voided check** may be mailed to:

ATTN: BILLING
AultCare Insurance Company
P.O. Box 6910
Canton, Ohio 44706

Scanned/electronic forms with **voided check image** may be securely emailed to: AultCareBilling@aultcare.com