PART J | CHOOSE ONE BILLING OPTION

IF NO OPTION IS SELECTED, YOU WILL BE BILLED DIRECTLY.

☐ **OPTION 1:** **Check here if you wish to pay through AUTOMATIC BANK WITHDRAWAL (Automatic Bank Withdrawals occur on the third business day of every month). Complete this Authorization, attach a voided check or a voided savings account deposit slip and then sign below:**

Name of bank (and branch if applicable) ______________________ ***Checking/Savings Account No.*** ______________________

I authorize Long Term Care Partners to initiate automatic bank withdrawals from my account shown above. I also authorize my bank to charge my account shown above for such withdrawals, payable to Long Term Care Partners.

This authorization will remain in effect until either I, my bank or Long Term Care Partners terminates it by a thirty (30) day written notice to the others. I understand that I won't receive any bills or other notices of the withdrawals from Long Term Care Partners.

I agree that if the automatic bank withdrawal isn't honored by my bank, for whatever reason, Long Term Care Partners will have no liability for the payments. I understand that my insurance coverage may be terminated because of non-payment of premiums. I also understand that I will receive notice of such non-payment from Long Term Care Partners before my insurance coverage is terminated.

Staple Voided Check or Voided Savings Deposit Slip Here

Depositor's Signature X ______________________ **Date** ____ / ____ / ____ (MONTH / DAY / YEAR)

Depositor's Signature X ______________________ **Date** ____ / ____ / ____ (MONTH / DAY / YEAR)

Signature must be signature of depositor(s) as shown on bank records for this account. If joint account, both depositors must sign.

☐ **OPTION 2:** **Check here if you wish to pay through PAYROLL/ANNUITY DEDUCTION.**

Refer to your *Payroll/Annuity Deduction Instruction Guide* in your kit. You must provide a Payroll/Annuity Office Identifier and any other information required below. If you do not, YOU WILL BE BILLED DIRECTLY.

Please provide the Payroll/Annuity Office Identifier for the Payroll/Annuity Office from which deductions will be made.

Payroll/Annuity Office Identifier: ______________ **(5 - 8 DIGITS/CHARACTERS)**

If deductions will be made from a Federal Civilian annuity, and there is an Annuity Claim Number, please provide it.

Annuity Claim Number: C S ___ ______________

INSERT (A, F, OR I) ABOVE AND FILL IN THE REMAINING 7 DIGITS/CHARACTERS

If you are requesting payroll/annuity deduction from someone else's pay/annuity, that person must complete the information above, provide the following information, and sign the authorization below:

Name of Employee/Annuitant: ______________________ (FIRST / MIDDLE INITIAL / LAST)

Social Security Number of Employee/Annuitant: _______ - _____ - _______

I hereby authorize Long Term Care Partners to deduct from my pay/annuity the amount necessary to pay the premiums for the Federal Long Term Care Insurance coverage for this applicant. This authorization may be cancelled only upon written notification to Long Term Care Partners from me or the applicant.

Payroll/Annuity Authorization Signature X ______________________ **Date** ____ / ____ / ____ (MONTH / DAY / YEAR)

☐ **OPTION 3:** **Check here if you wish to pay through DIRECT BILLING. You may request an alternate billing address by filling out the information below. If you leave this blank, we will use your address on page 1.**

Care Of ______________________ (FIRST / MIDDLE INITIAL / LAST)

Street Address ______________________

City ______________________ State/Territory ______________________

Country ______________________ ZIP Code/Foreign Postal Code ______________________