

# Pre-Authorized Check (PAC) Draft Authorization

For PAC, return this form and a voided check with your premium payment OR FAX to: 985-871-1855.

## Request for Monthly Payment of Medical\* Premiums by Automatic Bank Deduction (\*including group life premiums, if applicable)

As a convenience to me, I authorize **Gilsbar, Inc., Covington, LA, TIN #72-0519951** to debit premiums and, if necessary, make adjustments for any error to my account at the Bank (or other financial institution) I have indicated below. I also authorize said Bank to debit and, if applicable, credit the amount of those entries to my account made payable to the order of **Gilsbar, Inc., Covington, Louisiana**.

I understand and agree that:

- 1) My premium will be drafted on the **1st or 10th** day of each month;
- 2) The Bank's rights with respect to each charge will be the same as if personally executed by me;
- 3) This authorization will remain in effect until I provide written notification to Gilsbar, Inc. that I wish to revoke it. I will allow Gilsbar, Inc. thirty (30) days to act on this notice;
- 4) Gilsbar, Inc. and my Bank may discontinue this service; and
- 5) The presentation of any such debit or draft shall constitute due notice of premiums being due for a policy of insurance on my behalf and/or on behalf of my eligible dependents. I understand that should my Bank dishonor any such debit or draft for any reason, it will be my responsibility to make arrangements with Gilsbar, Inc. for premium payments within the grace period to prevent lapse or possible termination due to nonpayment in accordance with the terms of the policy.

### INSURED INFORMATION (premium payor)

(Please print in ink or type)

Name of Insured/Employer

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Name of Professional Membership Affiliation

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Certificate Holder ID (SSN)

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Month to Begin My PAC Service

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Daytime Telephone Number

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Signature of Premium Payor (must be identical to bank records)

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DATE

### BANK ACCOUNT INFORMATION

Name of Bank or Financial Institution

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Branch

City

State

Zip

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Name(s) as Appears on Bank Account

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Please circle one:

*Checking*

*Savings*

Account Number

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Bank Transit/Routing Encoding #

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\*Signature (If joint account, both signatures required)

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DATE

**MAIL TO: Gilsbar, Inc. • Administration Department • P.O. Box 2946 • Covington, LA 70434**  
**FAXTO: 985-871-1855**

Gilsbar, Inc., A member of the Gilsbar Group of Companies  
(985) 892-3520 • Toll Free (800) 445-7227 • [www.gilsbar.com](http://www.gilsbar.com)

HB #996605

