AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS

NAME _____ PHONE (__)_____

ADRESS _____ CITY _____ ST ____ ZIP_____

FINANCIAL INSTITUTION_____

CITY, STATE, ZIP _____

PLEASE ATTACH A VOIDED BLANK CHECK
(REQUIRED FOR PROCESSING)

I hereby authorize the Financial Institution named above to pay my monthly obligation by charging each payment to my account and to make that deduction payable to the order of Morgan White Administrators, Inc. (MWA). I agree that each payment shall be the same as if it were an instrument personally signed by me. This authorization will remain in effect until revoked by me in writing. In addition I have the right to stop payment of a charge by timely notification to my Financial Institution prior to charging my account. I understand, however, that both the Financial Institution and Morgan White Administrators reserve the right to terminate this payment plan (or my participation therein). By signing below I agree to the following terms:

1. **Payments will be posted on the 1st of each month and Morgan White Administrators should receive any changes prior to this date.**
2. **I understand that payments will debit my account between the 1st and 5th of each month, Delta Dental will debit my account between the 18th and 23rd of each month for the upcoming month.**
3. **MWA will post insurance rate increases to my account without requiring additional authorization.**
4. **Payments not honored will not be submitted a second time.**
5. **MWA will send notice of payment not honored.**
6. **If a payment is not honored my insurance terminates 30 days after notice has been sent.**
7. **If I wish to continue my insurance after a payment is not honored, full payment must be received by MWA prior to the end of that month.**
8. **If I wish to continue my insurance after a payment is not honored, Morgan White Administrator will charge a $30 fee in addition to any bank charges.**
9. **Reinstatement is only possible within 60 days of the not honored payment after that no reinstatement is possible.**
10. **After two (2) payments are not honored, reinstated is <u>not</u> possible.**

_____ X _____
DATE **PLEASE SIGN AS YOU SIGN CHECKS**

NOTE: Please return this authorization and a *VOIDED CHECK* to:

Morgan-White Administrators, Inc.
ACH ENROLLMENT
PO BOX 14067
JACKSON, MS 39236

<u>DRAFT CAN NOT BE PROCESSED WITHOUT A VOIDED ORIGINAL CHECK.</u>
<u>DEPOSIT SLIPS ARE NOT ACCEPTABLE!</u>

COMPANY USE ONLY: GROUP _____ I.D. NUMBER _____

AMOUNT $_____ DRAFT DATE ___/___/___