

**GENERAL AGENT CENTER  
PAYMENT CHANGE REQUEST FORM**

Dear Applicant:

If you want to change banks for your monthly automatic bank draft service, we need you to complete the Bank Draft Authorization Form below. Mail or Fax the **completed form** and a **voided check** to the address listed below. Feel free to call your agent or GAC with any questions.

**Toll Free Phone: 1-800-366-2467 ~ Toll Free Fax: 1-800-471-7996**

**Mailing address: General Agent Center ~ 11575 N. 79th Place ~ Scottsdale, AZ 83260**

APPLICANTS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

BANK DRAFT AUTHORIZATION AGREEMENT FOR AUTOMATIC MONTHLY PAYMENTS IN THE AMOUNTS LISTED BELOW FOR COVERAGE ON: \_\_\_\_\_ .

I hereby authorize the indicated payee(s) below to charge my account the insurance premiums and fees due monthly. *(I have also included the first month's premium and fees payable to said payee(s).)*

VBA (24 HOUR ACCIDENT / OR NEA VALUE ER PLAN) \$ \_\_\_\_\_

GEM ADMINISTRATORS (VALUE HEALTH / HOSPITAL PLAN) \$ \_\_\_\_\_

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA (UNL) \$ \_\_\_\_\_  
(VALUE MED PLAN in AR, ID, IL, MO, NE, NV, NM, ND, OK, SD, TX, UT & WV)

GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL) \$ \_\_\_\_\_  
(VALUE MED PLAN in approved states not listed above)

I understand my account will be charged once each month for the total amount shown as due for my monthly premium and fees for the term of the policy of insurance issued to me. I understand that if a charge to my account is not honored, my insurance coverage could lapse. I further agree that you will not be under any liability for any dishonored electronic withdraws from my account, for any reason, even though the dishonor results in the forfeiture of benefits or membership. If any ACH item is dishonored, I authorize any additional returned check fees resulting from said dishonored check, to be charged to my bank account. I understand that if I wish to cancel my coverage, I must inform the named insurance company above or GEM Administrators of such cancellation within 30 days of the withdrawal date. Please charge my monthly premium and fees against the following account.

\_\_\_\_\_  
Name of Depositor, as it appears on the Bank Institutions Records

\_\_\_\_\_  
Account Number Routing / Transit Number

\_\_\_\_\_  
Name of Banking Institution Branch

\_\_\_\_\_  
Address City State Zip

Please attach a voided check from the account you wish billed for your coverage.

X \_\_\_\_\_ Date Signed: \_\_\_\_\_