WPS™
A HEALTH SOLUTIONS COMPANY

PAYMENT AUTHORIZATION FORM

ACCOUNT HOLDER INFORMATION:

Name _____

Customer Number (if available) _____ Social Security Number_____-_____-_____

Mailing Address: Street/P.O. Box _____

City_____ State_____ ZIP_____ County_____

AUTOMATIC WITHDRAWAL:

Select One: ○ Checking Account ◉ Savings Account

Account Number _____ Routing Number _____

Bank Name _____

By my signature below, I authorize Wisconsin Physicians Service Insurance Corporation ("the Insurer") to instruct my financial institution to deduct my premium payments from the account designated above. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify the Insurer in writing of its termination. My notification must afford the Insurer and my financial institution reasonable opportunity to act on it.

PAYMENT WITHDRAWAL DATE:

Please select one of the following options for your recurring payment:

○ First day of the month

◉ 20th of the month prior

Note: Recurring premium payments will be charged to your checking/savings account based on your selection above. We will continue to charge premiums until the policyholder notifies us to discontinue charging premiums in accordance with the Insurer's policy. If you do not choose a day, the payment pull will occur on the 20th of the month **prior** to the payment due date.

MAIL PAYMENT TO:

WPS
P.O. Box 18232
PALATINE, IL 60055-0001

SIGN HERE _____ _____
Applicant Date

SIGN HERE _____ _____
Account Holder (if different from Applicant) Date

PLEASE EMAIL THIS SIGNED AND COMPLETED FORM TO **billing@wpsic.com**
OR FAX THIS SIGNED AND COMPLETED FORM TO **608-223-3639.**

FINANCIAL INFORMATION