PISI
PROFESSIONAL
INSURANCE SERVICES, INC

2 Kacey Court, Suite 102
Mechanicsburg, PA 17055
1-800-382-1352

PARSE

AUTHORIZATION FOR MONTHLY WITHDRAWAL

Dear PARSE Member:

The Monthly Withdrawal from your checking account is only available for the Dental premium. Vision premiums are to be paid in full. The Monthly Withdrawal option cannot be applied to a credit card.

- To enroll in the PISI Monthly Withdrawal option, complete, sign and mail the bottom half of this form. **You must include your Dental Application or Renewal Notice and your First Month's check made payable to "PISI" using the amount shown below.**

	First Month's Check	Eleven Monthly Withdrawals	ANNUAL TOTALS
INDIVIDUAL	$ 39.23	$ 39.07	$ **469.00***
TWO-PARTY	$ 72.49	$ 72.41	$ **869.00***
FAMILY	$111.24	$111.16	$**1,334.00***

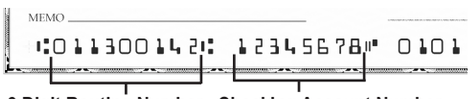
***includes a $20.00 processing Fee**

- Your check will pay the first month's premium. For the remaining 11 months of your contract PISI will debit your account. You will **not** receive monthly bills.
- PISI will request a transfer of payment from your bank account on the **10th day of each month.** If the 10th of the month falls on a weekend or holiday, the transfer will take place the next business day.
- Next year, at time of renewal, you will be notified of any changes in the plan benefits or cost but the monthly withdrawal will automatically continue, unlesss you choose to pay in full or advise of cancellation.

Keep top portion for your records. *A copy of the agreement is on the back.*

Detach and return this portion with your **Dental Application** *or* **Renewal Notice** *and* **First Month's check** *made payable to* **"PISI".**

I (we) authorize and request PISI to initiate electronic debit entries to my (our) account indicated on this form in the financial institution named on this form ("BANK"). I (we) authorize and request BANK to honor the debit entries initiated by PISI and debit these charges to that account. This authorization will remain in effect until all amounts owed related to the contract are paid in full, or until I (we) cancel this authorization. To cancel this monthly withdrawal I (we) must notify PISI and BANK in writing 60 days in advance to give PISI and BANK a reasonable opportunity to act. Cancellation of this electronic debit authorization does not cancel the terms of the Dental contract, I am agreeing to pay the full annual Dental premium.
I understand that the funds will be withdrawn on the 10th day of each month and that it is my responsibility to ensure sufficient funds are in my account at that time. If the 10th of the month falls on a weekend or holiday, PISI will initiate a debit entry on the next business day. If more than 2 withdrawals in a 12 month period are denied for any reason I understand I risk cancellation of my Dental Benefits.



9 Digit Routing Number Checking Account Number

Bank Name: _____

9-Digit Routing Number: _____

Checking Account Number: _____

Name on Checking Account _____ **Date** _____

Signature _____

Anyone else whose signature is required to withdraw funds from this account must sign here: _____ **Date** _____

Policyholder's Name (if different from above) _____

First Month's Check
☐ **$ 39.23**
☐ **$ 72.49**
☐ **$111.24**

For Office use only:
PARSE **#**_____ **M**_____ **W**_____

PARSE 7/16

Below is a copy of the Agreement you have entered into with Professional Insurance Services, Inc. for the purchase of United Concordia Dental Insurance. Please keep this copy for future reference.

I (we) authorize and request PISI to initiate electronic debit entries to my (our) account indicated on this form in the financial institution named on this form ("BANK"). I (we) authorize and request BANK to honor the debit entries initiated by PISI and debit these charges to that account. This authorization will remain in effect until all amounts owed related to the contract are paid in full, or until I (we) cancel this authorization. To cancel this monthly withdrawal I (we) must notify PISI and BANK in writing 60 days in advance to give PISI and BANK a reasonable opportunity to act. Cancellation of this electronic debit authorization does not cancel the terms of the Dental contract, I am agreeing to pay the full annual Dental premium.

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