

**Directions for completing authorized agreement for automatic premium direct debit**

Line 1: Fill in the name of the bank that you want debited for your premium payment.

Line 2: Fill in City, State and Zip Code of your bank.

Line 3: **Important! The transit/ABA No is the first series (usually 9 or 10 numbers) shown on your checks or deposit form.** (see next page for sample)

Line 4: **Important: Your checking account number is the next series of numbers after the transit/ABA numbers.** (see next page for sample)  
**or submit a copy of a voided check or deposit slip and attach it to this application.**

Line 5: Check the box for the appropriate type of account.

Line 6: Print primary insured's name and address.

Line 7: Fill in primary insured's social security number.

Line 8: Fill in your home phone number. (In case we need to contact you)

Line 9: Fill in your E-Mail address. (if you have one)

Line 10: Effective Month of Direct Debit. (debit occurs the 10th of each month)

Line 11: Date you signed this form.

Line 12: Your signature as shown on your bank account.

Please return this form to the attention of:

**Accounting Department**

**Authorized Agreement for Pre-Authorized Debit**

Company Name: **OEA Choice Trust**

Company Tax ID Number: **93-0763726**

I (we) hereby authorize OEA Choice Trust, hereinafter called the company, to initiate debit entries to my (our) account at the financial institution named below, hereinafter called the depository.

1. Bank Name: \_\_\_\_\_

2. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

3. Transit/ABA No: \_\_\_\_\_ 4. Account No: \_\_\_\_\_

5. Checking Acct:

Savings Acct:

**This Authority is to remain in full force and effect until the company and my bank have received written notification from me of its termination in such time and in such manner as to afford the company and depository a reasonable opportunity to act on it.**

6. Name(s) of insured: \_\_\_\_\_  
(please print)

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

7. Social Security # of insured: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 8. Phone #: \_\_\_\_\_

9. E-mail address: \_\_\_\_\_ 10. Effective Month: \_\_\_\_\_

11. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 12. Signed: \_\_\_\_\_

**If you have questions concerning the completion of this form please contact us by phone at 503-620-3822 or E-mail at [billing@oeachoice.com](mailto:billing@oeachoice.com)**