

Electronic Funds Transfer Form

8303 W. Higgins Road, Chicago, IL 60631 | FAX: 800-313-8955 | EMAIL: benefits@covchurch.org

provided below. Please print legibily.			
Name (employer or retiree):			
E-mail:		Phone #:	
Address:			
City:	State:	Zip	Code:
Bank Name:			
lame on bank account:			
Couting/ABA #:	Account #:		
Month to start:	Withdraw funds on:	☐ 8th day of month	20th day of month
Statement of Authorization. I hereby authorize the total monthly premium for the account(s) and will continue until Covenant Benefits recei	listed above. I understand and accept that ives written notification from me stating t	omatically withdraw from t this will begin in the moi his automatic withdrawal	my checking account nth I indicated above should be
Covenant Benefits account ID number: Statement of Authorization. I hereby authorize the total monthly premium for the account(s) I and will continue until Covenant Benefits receiverminated. I also recognize that withdrawals with the continue of the communication of the communication of the covenant Benefits receiverminated.	e the Evangelical Covenant Church to auto listed above. I understand and accept that ives written notification from me stating t	omatically withdraw from t this will begin in the mor his automatic withdrawal or on the first business da	my checking account onth I indicated above should be ay after.
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