



Montana's Insurance Carrier of Choice and Industry Leader in Service

**Electronic Funds Transfer Authorization
Agreement**

(Print this form, complete it, and mail to the Montana State Fund.)

Policy Holder Name:	Policy Number:	Policyholder Federal Tax ID Number:

(Check one)

Checking Account	<input type="checkbox"/>	Savings Account	<input type="checkbox"/>
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Bank Account Number					
Bank Routing Number					
Bank Name					
Bank Branch					
Bank Address					
City		State		Zip Code	

The above named employer hereby authorizes Montana State Fund, hereinafter called STATE FUND, to initiate variable entries to the employer's account indicated above for payment of the listed insurance premium. The EMPLOYER acknowledges that the origination of ACH transactions to the account shown must comply with the provisions of U.S. law.

This authorization is to remain in full force and in effect until STATE FUND has received written notification from the EMPLOYER of its termination in such time and in such manner as to afford STATE FUND and DEPOSITORY a reasonable opportunity to act on it.

Policyholder Signature:	Date:

Enclose a voided check or deposit slip from your account along with this application and mail to: Montana State Fund, Attention: Accounts Receivable, P.O. Box 4759, Helena, MT 59604-4759. If you have any questions about completing this form, please contact a Customer Service Representative at 406-444-6500 or 800-332-6102.