CIGNA Group Insurance
Life • Accident • Disability

ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION FORM

FOLLOW THESE EASY INSTRUCTIONS TO ENROLL:

1. Please complete all of the information requested whether you are enrolling for EFT service, requesting changes or canceling the service.

2. If you are receiving Survivor Income Benefits, please include the name of the deceased insured ("Certificate Holder").

3. Be sure to include a voided check *(if requesting EFT to your checking account)* or a deposit slip *(if requesting EFT to your savings account).*

4. Sign, date and return in the envelope provided. Please allow 4 to 6 weeks to process your authorization form.

Retain a completed copy for your records.

1. Please provide the following information:

Your Name:

Certificate Holder's Name*:

Address:

City: State: Zip:

Telephone No.:
area code ( )

CIGNA Policy/Account No.: Social Security No.:

* Include the name of the deceased only if you are receiving Survivor Income Benefits (please disregard if you are receiving Disability Benefits).

2. Select type of transaction:

☐ Request to enroll
☐ Request to cancel

Change the following information:
☐ Account Number
☐ Account Type
☐ Financial institution

3. Indicate type of account:

☐ Checking account *(include a blank personal check marked "void")*
☐ Savings account *(include a deposit slip if available)*

4. Provide the following information:

Name of Bank: Branch Office:

City: State: Zip:

Branch Telephone No.: Bank Account No.:

Bank Routing No.: (First nine digits of check code line)

5. Sign and date this authorization statement:

I authorize the Insurer of the policy/account number identified above ("Company") to deposit my monthly net benefit into the account and bank I have indicated above or such other account as the bank or any successor designates as my account. I also authorize you to debit my account for any deposits made in error. I understand that the EFT service is only available for personal accounts, not business or corporate. I also understand that the EFT service will stay in effect until I notify the company of cancellation on the EFT service authorization form. I accept the responsibility to notify the Company if there are any errors in my account and will not hold the Company liable if there are any errors or omissions in depositing benefit payments to my designated account.

Signature X Date

Retain a completed copy for your records.