State Sponsored Life Insurance (SSLI)
110 W Johnson Street, Suite 300
Staunton, VA 24401
(800) 462-7441

Direct Debit/Bill Enrollment Form

Name: _____ SSN or SSLI Account #: _____

Please complete either section A or B

A - DIRECT DEBIT AUTHORIZATION

Bank Name _____

Routing Number (9 digits) | | | | | | | | | | ○ Checking ○ Savings

Account Number (5-17 digits) | | | | | | | | | | | | | | | | | |

Debit Date (select one)	Frequency (select one)
◉ 1st	○ Monthly $_____
○ 15th	○ Quarterly (Monthly Cost x 3)
	○ Semi-Annually (Monthly Cost x 6)
	○ Annually (Monthly Cost x 12)

Debit Authorization Statement

By signing this form, I authorize Armed Forces Benefit Association (AFBA) to initiate electronic debit entries to my checking or savings account as detailed above. I understand that my coverage is effective the day I enroll or become eligible for insurance. If the Day of Deduction specified is greater than the 28th of the month, AFBA will default initial and subsequent deductions to the first day of the following month. If the Day of Deduction falls on a non-business day, the debit entry will occur on the next business day. I understand that processing by my financial institution may result in the debit entry being completed on a date different from the specified deduction date.

I understand the amount may change automatically due to adjustments in coverage, status, or monthly contributions based on age brackets. If my coverage is not current, I authorize AFBA to debit my account for any amount in arrears to bring my account up to date. If there is a variation in the debit amount of more than five dollars, I will receive advance notice from AFBA prior to the deduction of said funds from my account.

I may cancel this authorization at any time by providing AFBA with notice at least 5 days before the next scheduled deduction. I retain the right to dispute any errors related to these deductions. For further information, I can contact AFBA directly at 800-462-7441. I understand that I am responsible for updating any change to the banking information associated with this Authorization and notifying AFBA of any change within 20 days of any change. I am also responsible for ensuring that the account contains the necessary funds to process the monthly withdrawals authorized by this form. I understand AFBA will not be held responsible for any overdraft fees or similar fees associated with an insufficient funds finding should the account fail to have the appropriate amount necessary to complete each monthly withdrawal.

I warrant and represent that (i) I am the owner of the referenced account and have the authority to sign and authorize this electronic funds transfer form and (ii) that the referenced account has been established for personal, family, or household use, and not for commercial purposes.

This authorization will remain in effect until canceled by AFBA upon written notice to me or revoked by me or my authorized representative. AFBA will retain a copy of this authorization for a minimum of two years following termination. Contributions may be used by AFBA to fund member death benefits through the purchase of life insurance from its affiliate, 5 Star Life Insurance Company.

B - DIRECT BILL AUTHORIZATION

Please bill me at my address on file: ○ Quarterly ○ Semi-Annually ○ Annually

There is a $25.00 minimum for bills. Invoices under $25.00 will be moved to the next frequency until they meet this minimum.

THIS FORM MUST BE SIGNED AND DATED TO BE VALID

Signed: _____ Date (MM/DD/YYYY): ____/____/____

Revised 11/25