WISCONSIN MUTUAL INSURANCE COMPANY

EFT BILLING PROGRAM GUIDELINES

Description - Wisconsin Mutual Insurance Company's EFT Billing Program is designed to offer the convenience and security of automatic premium payments on a regular basis through either a checking or savings account from your bank. You may elect to have the premium payments withdrawn monthly (6 month term, 12 month term if Umbrella), quarterly (3 month term), semi-annual (6 month term) or annually (12 month term).

Eligibility - All lines of business are eligible for the EFT Program.

Fees - A $1.00 fee will be charged for all EFT Billing Program transactions processed. If multiple policies have the same withdrawal date, only one fee will be charged.

MONTHLY WITHDRAWALS - 6 MONTH TERM

Applying - New business and renewal business require two months premium paid in full and the completed EFT Request. The first withdrawal would be one month after the effective date of the policy if new business or one month after the effective date of the renewal if existing business.

Payments - A Withdrawal Notice will be mailed at the beginning of each term and with each change showing the withdrawal date and amount. Subsequent withdrawals would be made on the same day of the month as stated on the original notice. All changes will be spread evenly over the remaining withdrawals in the term.

NSF's - If a withdrawal is not honored by the bank, a cancellation notice will be mailed to the insured. If it is the first return for NSF within a two year period, the policy will be reinstated if two months premium plus a $20.00 reissue fee is received prior to the cancellation date. The policy will be placed back on the EFT program with the existing bank information. If you have two NSF returns in a two year period no offer for reinstatement will be made.

TERM WITHDRAWALS - THREE, SIX or ANNUAL WITHDRAWALS

Applying - New business requires $200.00 and the completed EFT Request. The balance will be withdrawn in full with withdrawal date and amount noted on new business notice. Existing business requires the completed EFT Request prior to the renewal date. The balance due from the renewal will be withdrawn on the effective date of the renewal.

Payments - A notice will be mailed showing the withdrawal date and amount for all renewals and changes.

NSF's - If a withdrawal is not honored by the bank, a cancellation notice will be mailed to the insured. If it is the first return for NSF within a two year period, the policy will be reinstated if the full term premium plus a $20.00 reissue fee is received within 45 days from the date of withdrawal. The policy will be placed back on the EFT program with the existing bank information. If you have two NSF returns in a two year period no offer for reinstatement will be made.

Wisconsin Mutual

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Madison, Wisconsin 53717-1907

(608) 836-4663 FAX# (608) 836-1645

EFT BILLING PROGRAM

AUTHORIZATION AGREEMENT - FOR AUTOMATIC WITHDRAWALS AND DEPOSITS

A FEE OF $1.00 WILL BE APPLIED PER TRANSACTION, REGARDLESS OF THE NUMBER OF POLICIES

WITHDRAWAL FREQUENCY/POLICY TERM (CHECK ONE)

____ MONTHLY (ALL LINES 6 MONTH TERM WITH MONTHLY WITHDRAWALS EXCEPT UMBRELLA 12 MONTH TERM WITH MONTHLY WITHDRAWALS. WITHDRAWALS ONE MONTH IN ADVANCE)

____QUARTERLY (POLICY TERM 3 MONTHS, WITHDRAWALS ONCE EVERY 3 MONTHS)

____SEMI-ANNUAL (POLICY TERM 6 MONTHS, WITHDRAWALS ONCE EVERY 6 MONTHS)

____ANNUAL (POLICY TERM 12 MONTHS, WITHDRAWALS ONCE EVERY 12 MONTHS)

BY SIGNING THIS AGREEMENT, I AUTHORIZE WISCONSIN MUTUAL TO CHANGE THE POLICY TERM TO THE ONE SELECTED ABOVE AND ALL POLICIES ON THE EFT PROGRAM WILL BE CHANGED TO THE SAME EFFECTIVE DATE.

POLICY NUMBER(S) ____

I (we) hereby authorize WISCONSIN MUTUAL INSURANCE COMPANY hereafter called COMPANY, to initiate withdrawals or deposits to my (our) account indicated below and the depository named below, hereinafter called DEPOSITORY, to withdraw or deposit the same to such account.

DEPOSITORY NAME	BRANCH	TRANSIT/ABA NUMBER
CITY, STATE, ZIP		ACCOUNT NBR
	TYPE OF ACCOUNT (Select One)	_____ CHECKING _____ SAVINGS

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME (PLEASE PRINT) DATE

SIGNATURE

NAME (PLEASE PRINT) DATE

SIGNATURE

ATTACH COPY OF CHECK HERE