



Disability / Critical Illness / Life / Worksheet

CONTACT INFORMATION

Name: _____

Phone: _____ Fax: _____

e-mail: _____

Monthly Rate Calculation

DISABILITY: Selected Disability Plan Rate _____

CRITICAL ILLNESS: Selected CI Plan Rate _____

TERM LIFE : Selected Term Life Plan Rate _____

Administration Fee: \$6.00 or \$3.00 (see below)

Total Monthly Payment: _____

I hereby authorize Kelsey National to take the above indicated **Total Monthly Payment** deduction, for the insurance products listed, from my checking account as listed on the attached Bank Draft Authorization form.

X _____
Signature Date

Administrative fee of **\$6.00** if you receive a **paper invoice** each month or **\$3.00** if you select to have an **auto debit** from your bank account each month. If making the auto debit selection, complete the "**Auto Draft Form**" and submit with your application. **Do not** include a premium check for **auto debit selection**. You **must include** a premium check for the **paper invoice selection**. There will also be a **one time account setup fee of \$20.00** which should be included with the initial payment check.

Make check payable to: Kelsey National Corporation

Mail this form along with your completed application(s), benefit checklist, and copies of all required documents to:

Vantage Business Support & Insurance Services
1420 E Roseville Pkwy., Ste. 140-402
Roseville, CA 95661

NOTE: All applications received during any month will be effective the 1st of the following month. Incomplete applications will not be processed until all documents are received.