ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION FORM

225 South East Street • P.O. Box 7192 • Indianapolis, IN 46207-7192
Phone: 1-800-428-3001
Fax: Pre-Existing Inforce Policy: 317-692-8402
Fax: New Policy Application: 317-692-7711

Only complete this section for a New Policy Application: (Please select only ONE option)

- The initial modal premium **must** be quoted in Section 5 of the application. We do not accept debit or credit cards.
- The policy may be placed on direct quarterly mode temporarily if we do not receive complete bank information or if there is a difference in premium quoted.
- **I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the premium paid.**

☐Draft my account for the first premium (initial premium may be drafted **immediately upon receipt** of this application in the Home Office). Please draft subsequent premiums on the _____ day of each month.

☐Draft my account for the first premium on: _____. All subsequent drafts will occur on this same day each month. (Month & Day)

☐Do NOT draft my account for the first premium. The initial premium is attached, is being mailed, or will be collected on delivery. **When providing a payment, do not leave Payee blank, do not make payable to the agent, or do not post date**. Please draft subsequent premiums on the _____ day of each month.

Must complete this section for a New Policy Application or any pre-existing inforce policy.

Bank Name _____ Bank Address _____

I request and authorize my financial institution to honor deductions from my account that are initiated by United Home Life or United Farm Family Life Insurance Company for the current policy premium. This authorization is to remain in effect until terminated and will apply to policy renewals or changes.

I understand and agree that:

- I may terminate this EFT authorization by giving 15 days prior written notice directly to the Company.
- The Company may terminate the agreement upon any deduction returned as dishonored.
- A deduction that is dishonored will not be resubmitted.
- A deduction that is dishonored may result in cancellation of insurance for non-payment of premium.
- The Company is not responsible for any charges from my financial institution.

Policy Number: _____ Name of Insured _____

Requested Deduction Date (1st – 30th): _____ (If date is not specified, the deduction date will default to date of issue)

Bank Account Number: _____ ☐Checking ☐Savings

Routing Number: _____

Bank Account Holder Printed Name: _____

Relationship to Insured: _____

Signature of Bank Account Holder: _____ Date: _____

HOME OFFICE USE ONLY

_____	_____	_____	_____
Call Representative/ACID	Date	Time	Call ID#