

ELECTRONIC FUND TRANSFER (EFT)

AUTHORIZATION FORM

225 South East Street • P.O. Box 7192 • Indianapolis, IN 46207-7192

Phone: 1-800-428-3001

Fax: New Policy Application: 317-692-7711

Fax: Existing In Force Policy: 317-692-8402



Section 1 – Financial Institution Information - Always Complete This Section

Financial Institution Name		
Account Number	Routing Number	Type of Account (check one) <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Account Holder Printed Name		Relationship if other than Owner Select one:
Account Holder Address		

Section 2 – Complete This Section For A New Policy Application

Name of Proposed Insured
The initial modal premium must be quoted in the payment information section of the application. We do not accept debit or credit cards at the time of application. I understand that the 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 the Owner's written acceptance of the policy if issued other than applied for and the premium paid.
1. Draft my account for the first premium (check one): <input type="checkbox"/> Immediately upon receipt of the application in the Home Office. <input type="checkbox"/> On the date of issue (policy date). <input type="checkbox"/> On ____ (month & day). Choose any day between the 1 st and the 28 th . <input type="checkbox"/> On the [<input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th] (check one) Wednesday of ____. <input type="checkbox"/> Do NOT draft my account for the first premium. The first premium is attached, is being mailed, or will be collected on delivery. The Company name should appear as the Payee. Do not leave the Payee field blank, do not make payable to the agent, and do not postdate. Do not pay with cash.
2. Unless indicated below all subsequent premiums will be drafted on the same day each month as the first premium. Draft subsequent premiums on the __ (1 st – 28 th) day of each month.

Section 3 – Complete This Section For An Existing In Force Policy

Name of Insured	Policy Number
Requested draft day __ (1 st – 28 th) OR the [<input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th] (check one) Wednesday of each month. If day is not specified, the draft day will be based upon the date of issue (policy date).	
Billing Mode: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual If the billing mode is not specified, the billing mode will default to monthly.	

Section 4 – Authorization – Always Complete This Section

I request and authorize my financial institution to honor deductions from my account that are initiated by United Home Life Insurance Company or United Farm Family Life Insurance Company (the "Company") for the current policy premium, including policy renewals and/or changes. By signing below, I authorize the Company to receive information from the financial institution named so my account number and routing number may be verified.	
I understand and agree that the Company is not responsible for any charges from my financial institution. A dishonored deduction may be resubmitted. A dishonored deduction may cause the policy to lapse for non-payment of premium. I may terminate this EFT Authorization by giving 15 days prior written notice to the Company. The Company may terminate this EFT Authorization agreement upon any deduction returned as dishonored, or upon 15 days prior written notice.	
Account Holder Signature _____	Date _____

HOME OFFICE USE ONLY

Call Representative/ACID	Date	6:12 AM Time	Call ID#
--------------------------	------	-----------------	----------