REQUEST FOR EFT PREMIUM PAYING PLAN

Bank Name _____

Bank Address _____

_____

Bank Phone _____

Branch Name (if any) _____

Account Owner Name _____

Routing # **(Must be 9 digits)** _____

Account Number _____

Account Type: **( ) Checking ( ) Savings**

Beginning in the Month of _____

Withdrawal Day (no later than 28th of month)*_____

Withdrawal Amount (Universal Life only) $_____

Loan Repayment Amount (optional) $_____

*Universal Life will be drafted equal to or before the policy effective date

POLICY NUMBER (IF APPLICABLE)	NAME OF INSURED / PROPOSED INSURED	FOR COMPANY USE ONLY

AUTHORIZATION

I authorize the payment of debits drawn on my account payable to Columbian Mutual Life Insurance Company or Columbian Life Insurance (the Company), for the payment due for each policy identified on this request form, provided there are sufficient funds in the account. I agree that the Company shall be under no liability whatsoever in the event of one or more dishonored debits, whether any alleged harm or damage is directly or indirectly the result of the dishonor and whether the dishonor results in the forfeiture of insurance or any other harm or damage.

I hereby waive any requirement for giving notice of premiums due as long as this EFT Plan is in effect. No premium shall be deemed to have been paid until the Company receives actual payment which is not subsequently reversed. The use of this plan shall in no way change the provisions of the policy with respect to the termination of such policy upon nonpayment of the premium due.

This authorization shall not become effective unless and until the policy or policies applied for are issued and delivered and shall relate only to premiums thereafter falling due. This authorization does not waive repayment of any policy loan or payment of interest thereon. Such interest, if any, shall be due and payable annually on the policy anniversary. If premiums are being paid under this plan and you have a loan on your policy, you may request an additional amount to be drafted from your account monthly to be applied to reduce the loan. During the continuance of this plan, any dividend which, in the absence of this authorization, would be applied in reduction of premium shall instead be paid in cash. This plan shall continue in effect until terminated by the Company or by me upon thirty days written notice to the other party.

The Company may terminate the EFT Plan if any check or electronic funds transfer is not paid on presentation. Upon termination of the EFT Plan, premiums due under the policy shall be payable directly to the Company at the minimum modal premium available at the time of issue. I understand the monthly premium charged under the EFT Plan may be lower than a regular monthly premium. Withdrawals will be processed on or about my requested withdrawal date. The Company is not liable if withdrawals are made on differing date(s). In addition, the Company may terminate the plan immediately if any two checks or electronic fund transfers within any twelve month period are not paid on presentation.

My signature below authorizes the Company to draft ALL DUE premium to bring my policies current. The first draw will include any past-due premiums.

X _____ Date

X _____ Primary Authorized Signature as it Appears on Bank Records

X _____ Secondary Authorized Signature as it Appears on Bank Records

X _____ Address – City – State – Zip Code

X _____ Please provide telephone number for any questions we may have

PLEASE ATTACH A VOIDED CHECK OR SAVINGS DEPOSIT SLIP HERE

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • HOME OFFICE: BINGHAMTON, NY
COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICES: BINGHAMTON, NY • SYRACUSE, NY
MAILING ADDRESS: **PO BOX 1056 • SYRACUSE, NY 13201-1056**
TELEPHONE: (800) 347-0960 FAX: (315) 413-7549