



**Bank Draft Authorization**

As a convenience to me, I hereby request and authorize the banking institution below (the "Bank") to pay and charge to my account drafts on my account by and payable to the order of the company who issued or assumed the policy listed below (the "Company") administering my insurance policy provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the Bank's rights in respect to such draft shall be the same as if it were a check drawn on the bank and signed personally by me. This authority is to remain in effect until revoked by me. I agree that the Bank shall be fully protected in honoring any such draft. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, the Bank shall be under no liability whatsoever. Should any draft not be honored by the Bank upon presentation, I understand that this method of payment may be terminated.

I understand that Americo requires a five business day advance notice to set up, change, or discontinue my bank draft information. I understand also that my insurance policy may lapse if said draft is returned unpaid by my Bank or if I discontinue payments prior to receiving confirmation of draft processing from the Company.

**REQUESTED DRAFT DATE:** \_\_\_\_\_ (NOTE: Bank drafts cannot occur on the 29<sup>th</sup>, 30<sup>th</sup>, or 31<sup>st</sup> of the month.)

**FOR NEW BUSINESS APPLICATIONS:** Unless otherwise requested, premium will be drafted from your account IMMEDIATELY upon policy issuance.

**FOR EXISTING POLICIES:** Unless otherwise requested, premium draft date will be the existing premium due date.

- CHECK ONE:**
- Checking account (attach voided check)
  - Savings account (attach deposit slip)
  - Cash with Application (use the deposit and routing number from the enclosed check in lieu of a voided check)
  - Please use Bank Draft information from Americo policy number: \_\_\_\_\_

**PAYOR INFORMATION (complete only when Payor is different than Proposed Insured or Owner)**

|      |                                  |                        |
|------|----------------------------------|------------------------|
| Name | Relationship to Proposed Insured | Social Security Number |
|------|----------------------------------|------------------------|

Address (If mailing address is a P.O. Box, a street address is also required)

How long at current address? \_\_\_\_\_ If less than 5 years at current address, prior address required.

|                     |                  |
|---------------------|------------------|
| Insured (s) Name(s) | Policy Number(s) |
|                     |                  |
|                     |                  |
|                     |                  |

\_\_\_\_\_  
**Payor's Signature** (as it appears on bank records)

\_\_\_\_\_  
**Date Signed**

**Attached voided check or deposit slip here.**

Please direct correspondence in reference to this draft to: PO Box 410288  
Kansas City, MO 64141-0288  
Phone: (800) 231-0801