SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607-723-3551 • www.smlny.com

AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (EFT) PAYMENTS

Policy Information:

Policy Number: _____

Insured Name: _____

Policy Effective Date: _____

Initial Premium needed to place Policy in force: $ _____

Recurring Premium: $ _____

Recurring Premium Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Authorization (select one):

❑ I do not authorize Electronic Funds Transfer (EFT) Payments at this time.

❑ I/we, _____ hereby authorize (this **"Authorization"**), and confirm
(Name of payor and any joint Accountholder as appears on Financial Institution Records)
that I/we are entitled to authorize, Security Mutual Life Insurance Company of New York (the **"Company"**) to, in accordance with my/our selections below: (i) initiate a debit entry sufficient to pay the premium (**"Premium"**) due on the life insurance Policy listed above, (ii) initiate recurring debit entries to pay all subsequent Premium payments on the Policy above, and (iii) initiate any debit entries and adjustments necessary to correct any erroneous entries (all such debit entries and adjustments are collectively referred to as **"EFT Transactions"**), each from the following account (**"Account"**) at the financial institution (**"Financial Instution"**) listed below:

Payment Options (select <u>one</u>)**:**

❑ Initial Premium only: Complete **"A"** below - *we will <u>not</u> debit Recurring Premiums.*

❑ Recurring Premium only: Complete **"B"** below - *we will <u>not</u> debit the Initial Premium.*

❑ Initial and Recurring Premiums: Complete **"A"** and **"B"** below - *we will debit the Initial Premium <u>and</u> debit Recurring Premiums.*

➢ **A** *(Initial Premium)*:

Payment Date:* _____

Payment Amount: ❑ Initial Premium amount (see above)

❑ Other: $ _____

➢ **B** *(Recurring Premium):*

Payment Date:* _____ day of the month
(1st -28th)

Payment Amount: Recurring Premium amount (see above)

***Payments will begin only after the necessary payment Authorizations have been received and all Policy delivery requirements have been satisfied.**

Bank Information:

Name of Financial Institution: _____

Routing/Transit Number: _____

Account Number: _____ Choose <u>one</u>: ❑ Checking account ❑ Savings account

Terms & Conditions:

I/we authorize the Financial Institution to accept this Authorization. **In consideration for honoring this request, I/we understand and agree to the following:**

1. For Recurring Premium payments, the Company will initiate periodic EFT Transactions on or about the Payment Date for each month in which a Premium payment is due depending on the selected Recurring Premium Frequency. If no Payment Date is specified, the default Payment Date will be the 15th day of the month (or, if the Payment Date falls on a weekend or holiday, the next business day) in which the Premium payment is due. **It may take up to 60 days for payments to start. During that time, if payments are not taken out, the first payment may be larger to include payment for the prior periods.**
2. For the Initial Premium payment, if no Payment Date is specified, the default Payment Date will be immediately following the Company's receipt of this signed Authorization and all necessary Policy delivery requirements. If the Payment Date falls on a weekend or holiday, we will debit the Initial Premium on the next business day.

3. I/we recognize that the Premiums are due and authorize any required notice of Premium due be waived. Unless required under applicable laws, the Company will not be required to give notice of upcoming payments or Premiums coming due.
4. In order to ensure the Policy is current in its Premium payments, which includes the cost of One-Year Term Additions under any Term and Paid-Up Additions Combination Rider attached to the Policy, I/we authorize the Company to increase the Recurring Premium payment amount above, if and when necessary, up to a maximum of $100 above the Recurring Premium payment amount above. I/we have the right to receive at least 10 days' notice of any EFT Transaction amount that varies from the Recurring Premium payment amount above. However, for convenience, I/we only want to receive notice of a varying EFT Transaction amount if it varies by more than $100 from the previous Recurring Premium payment amount. If I/we want to receive notice of every varying EFT Transaction amount in the future, I/we will contact the Company at 800-765-6668.
5. If the Account is held jointly with one or more persons, I/we verify that I/we have permission to authorize the Company to process EFT Transactions from the Account.
6. If any EFT Transaction is not honored on presentation and if sufficient Premium is not paid within the Policy's grace period, the Policy will lapse in accordance with its terms.
7. EFT Transactions will be automatically revoked by the Company if any two EFT Transactions within any twelve-month period are not paid on presentation.
8. This Authorization shall not be construed as a modification of any of the provisions of the Policy.
9. EFT Transactions may be discontinued at any time by the Company, me/us, or the Financial Institution, by giving 15 days' written notice.
10. If EFT Transactions are terminated, Policy Premiums falling due thereafter shall be payable directly to the corporate office of the Company in accordance with Policy provisions.
11. Notification of Account change must be received by the Company no less than 15 days prior to the next deduction.
12. Subject to applicable laws, the Company reserves the right to recover any erroneous EFT Transactions.
13. Payment of Premiums other than annually may result in an additional expense (this does not apply for a Universal Life Insurance Policy).
14. EFT Transactions requests will be presented twice to your Financial Institution before being returned as "unpaid." The Company assumes no responsibility for determining your authority to act on behalf of the above referenced Account, nor for Non-sufficient Fund Fees (NSF Fees) assessed by your Financial Institution. To prevent overdrawing your Account, consider overdraft protection. See your Financial Institution for details.

By signing this document, I agree that a copy of this document transmitted by facsimile or other electronic means shall be valid and binding as the original executed document. I hereby indemnify and hold the Company harmless from any liability incurred by the Company in reliance on my signature to this Authorization.

Signature of Accountholder *(If a Business Account, we require the signature and title of the person authorized to sign on behalf of the business.)*	**Print Name of Accountholder**	**Date of Signing**
Signature of Joint Accountholder(s) *(If required by the Financial Institution.)*	**Print Name of Joint Accountholder**	**Date of Signing**

Accountholder Daytime Telephone Number