REQUEST FOR EFT PREMIUM PAYING PLAN

	Bank Name Bank Address	A a a a consta Normalia a m	
Beginning in the Month of Withdrawal Day / Frequency Account Owner Name Withdrawal Day / Frequency Mithdrawal Amount (UL ONLY) POLICY NUMBER (F 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 Companyment due for each policy identified on this request form, provided there are sufficient funds in the account. I agree that the Company shall be unwhatsoever 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 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 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 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 premiur falling due. This authorization does not pertain to or waive repayment of any policy loan or payment of interest thereon. Such interest, if any, shall be due annually on the policy anniversary. During the continuance of this plan, any dividend which, in the absence of this authorization, would be applied in premium shall instead be paid in cash. This pian shall continue in effect until terminated by the Company or by me upon thirty days written notice to the company at the minimum available at the time of issue. I ungerstand the monthly premium chall relate only by me upon thirty days written notice to the company at the minimum available at the time of issue. I ungerstand the monthly premium. Withdrawals are made on differing date(s), in addition, the Company may terminate		Account Type:	 () Checking
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Date Primary Authorized Signature as it appears on Bank Records Secondary Authorized Signature as it appears on Bank	, ,		O J .
X		e as it appears on Bank Records X Secondo	ary Authorized Signature as it appears on Bank Records
	XAddress - City - State - Z	XPlease p	rovide telephone number for any questions we may have

THIS FORM MUST BE SIGNED ABOVE FOR YOUR REQUEST TO BE PROCESSED

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 1381 • BINGHAMTON, NY 13902-1381 TELEPHONE: (800) 423-9765 FAX: (877) 319-2463