Taylor ISD
Continuation of Coverage Options
at Retirement or Termination

Plan	Continuation of Coverage Options
Medical	Eligible for continuation under COBRA; contact Aetna at 800-222-9205 and and Scott and White at 1-800-321-7947.
Dental & Vision	Eligible for continuation under COBRA for up to 18 months; contact National Benefit Services at 800-274-0503.
MEDlink GAP	Eligible for continuation under COBRA for up to 18 months if the TRS medical plan is also taken under COBRA; contact American Public Life at 800-256-8606.
Healthcare FSA	You may be eligible for continuation under COBRA through your current plan year; contact National Benefit Services at 800-274-0503 to see if you qualify.
Cancer & Accident Group #1486	Eligible for continuation through direct billing basis with the insurance company; contact Loyal American at 800-366-8354.*
Basic & Voluntary Life	Eligible for portability or conversion. A form must be submitted to the insurance company to continue coverage. For more information, contact your school district benefit administrator or visit www.mybenefitshub.com/taylorisd to print the forms. You can contact OneAmerica at 1-800-553-5318 about Basic and Voluntary Life. *
Portability & Conversion differences	**Portability** coverage continues to function under the rules/guidelines of the group plan, coverage terminates at age (70) and premiums are tobacco/non-tobacco rated. **Conversion** converts group coverage to an individual whole life policy and you become the policy owner. Premiums are tobacco/non-tobacco rated.
Heart & Stroke	This plan is portable by calling Allstate at 800-521-3535 to advise the insurance company you would like to set up your policy on direct bill through bank draft for your premium payment.*
Individual Life Group #SM5141	Eligible for continuation through direct billing basis with the insurance company; contact Texas Life Insurance at 800-283-9233.*
Telehealth	Contact MDLIVE at 888-365-1663 to convert to an individual plan, different rates may apply.
Note *	**You have 31 days from the date of termination to submit a application with check directly to the insurance company. Portability /Conversion /Bank Draft forms are attached for your convenience.**

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY℠

THIS FORM MUST BE COMPLETELY FILLED OUT TO BE ACCEPTED

Proposed Insured's Name	**Policy Number (Home Office Only)**

If the account to be drafted is a Dedicated (Checking or Savings) or Savings account, fill in the shaded boxes.
If this is a Personal/Business Checking Account you must attach a voided check for processing. Staple voided checks on the box below.

SEG Name (Selected Employer Group) if applicable:	
Name of Financial Institution:	
Address & Phone Number of Financial Institution:	
Transit No. & Routing	**Savings or Dedicated Account No.**

Bank account is (Check appropriate box)

☐ Personal checking account
☐ Personal savings account
☐ Corporate/Business checking account
☐ Dedicated Draft Checking account
☐ Dedicated Share Savings account

Purpose for submitting this authorization (Check appropriate box/boxes):

☐ **New pre-authorized payment plan**
☐ Change in checking account
☐ Change in savings account
☐ Change in the Dedicated account noted above
☐ Change in bank
☐ Addition of new policy to plan
☐ Change in existing coverage

Desired date for withdrawal from checking/savings account. (Any date between the 1st and 28th of each month):_____

TOTAL AMOUNT OF PAYMENT FOR THIS POLICY $_____

Withdraw My Payment:_____Monthly_____Quarterly_____Semi-Annually_____ Annually

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS:

As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Loyal American Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR LOYAL AMERICAN LIFE INSURANCE COMPANY℠:

It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by Loyal American. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by Loyal American if any draft is not not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Loyal American upon 30 days written notice.

Print name as it appears on account	Date
Signature of depositor	

Application to Continue/Port or Convert Group Insurance

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® *company*
One American Square, P.O. Box 368
Indianapolis, IN 46206
1-800-553-5318
Fax: 1-888-285-7542
www.employeebenefits.aul.com

OneAmerica®

Continuing Insurance After Coverage Termination

If coverage under American United Life Insurance Company® (AUL) Group Insurance contract terminates, in some contracts eligible insureds may be able to continue paying premiums and keep existing insurance in force. Eligible insureds have 31 days from the date coverage terminates under the contract to apply and pay the required premium to AUL. *Eligible insureds will not be eligible to apply at a later date to continue this coverage.*

Section I - You should complete Section I making certain you apply for all the coverages you want to continue. By completing Section I you are indicating your desire to continue this application process and receive additional instructions and premium rate information.

Section II - Your Employer should complete Section II. The Employer should indicate all coverages you had at the time your coverage terminated.

AUL will review the information provided and then determine your eligibility to continue existing coverage. Once AUL has established your eligibility for continuing coverage, additional instructions and premium rate information will be provided.

Continuation of Group Disability Income and Lump Sum Disability Insurance

- In order to apply for the Conversion or Portability Privilege in AUL's Group Disability Income and Lump Sum Disability Insurance contract, eligible insureds must have been insured under the group contract for at least 12 consecutive months.
- If the insured is approved for continued disability coverage under the Conversion or Portability Privilege, coverage under that disability income or Lump Sum Disability Insurance contract is for only **12 months**.
- If the insured is approved for continued disability coverage under the Portability Privilege, the maximum benefit duration for any payable claim under that contract is the lesser of:
  1) the maximum benefit duration in effect immediately prior to termination of coverage under the prior group disability insurance contract; or
  2) two years.
- If the insured is approved for continued Lump Sum Disability Insurance, the Portability Privilege provides a Lump Sum Disability benefit equal to 50% of the coverage the person had immediately prior to the date coverage under the group policy terminated.
- If the insured is approved for benefits under the Conversion or Portability Privilege, any claim under that contract is subject to the same benefit provisions, such as a pre-existing condition exclusion.
- The Conversion and Portability benefits may not be available to an individual who: (please consult your policy and/or certificate)
  - ✦ no longer belongs to a class eligible for coverage under the contract;
  - ✦ has retired;
  - ✦ fails to pay any required premium;
  - ✦ is or becomes insured for any other similar group disability income insurance within 31 days after termination under AUL's contract;
  - ✦ is disabled under the terms of the contract;
  - ✦ is on a leave of absence;
  - ✦ was insured under a contract that terminated;
  - ✦ enters Active Military Duty for more than 30 days; or
  - ✦ establishes residence outside the United States or Canada.

Application to Continue/Port or Convert Group Insurance

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 368
Indianapolis, IN 46206
1-800-553-5318
Fax: 1-888-285-7542
www.employeebenefits.aul.com

OneAmerica®

Section I – TO BE COMPLETED BY EMPLOYEE

Employee Name: _____ Employer Name: _____

Date of Birth: _____ Social Security Number: _____ Gender: ☐ Male ☐ Female

Employee Address: _____

City: _____ State: _____ Zip: _____

Employee Phone Number: _____

Employee Email Address: _____

Were you disabled at the time coverage terminated? ☐ Yes ☐ No

If "Yes", have you applied for: ☐ Life Insurance Waiver of Premium Benefit ☐ Short Term Disability Benefits ☐ Long Term Disability Benefits ☐ Lump Sum Disability Benefits

Are you leaving present employment for new employer? ☐ Yes ☐ No

If "Yes", does the new employer offer: Group Life Insurance? ☐ Yes ☐ No
Disability Insurance? ☐ Yes ☐ No

If "Yes", does insurance become effective within 31 days? ☐ Yes ☐ No

1. Conversion of Life Insurance

Under the Conversion Privilege in the Group Term Life Insurance contract, eligible insureds can apply to convert existing life insurance coverage to an Individual Whole Life Insurance contract. If you wish to begin the application process for the Conversion Privilege, check the box next to the coverage(s) for which you are currently insured and wish to convert. Not checking a box will be considered declination of the Conversion Privilege benefit.

☐ Basic Term Life
☐ Voluntary Term Life
☐ Supplemental Term Life
☐ Voluntary Dependent Term Life
☐ Basic Dependent Term Life

Have you smoked cigarettes or cigars, used a pipe or smokeless tobacco, or chewed tobacco in the past 12 months?
☐ Yes ☐ No

Dependents for which you are applying to convert coverage under the Conversion Privilege in the Group Term Life Insurance contract: (Only complete this section if dependent was insured at the time coverage terminated.)

Name	Relationship	Date of Birth	Full Time Student	Disabled
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Have any of the above dependents smoked cigarettes or cigars, used a pipe or smokeless tobacco, or chewed tobacco in the past 12 months? ☐ Yes ☐ No If "Yes", list those individuals: _____

AUL will review the information provided and determine your eligibility for Conversion. Once AUL has established your eligibility for Conversion, additional application instructions and premium rate information will be sent to you for further review and action. The maximum amount of coverage converted to an Individual Whole Life Insurance policy cannot exceed your current amount of coverage approved by AUL.

Please remember to sign Employee Section page 3 and keep a copy for your records.

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Section I – TO BE COMPLETED BY EMPLOYEE (continued)

Employee Name: _____ Employer Name: _____

2. Continuation/Portability of Voluntary Term Life Insurance

Under the Continuation and/or Portability Privilege in the Group Voluntary Term Life Insurance contract, eligible insureds can apply to continue existing coverage. If you wish to begin the application process for the Continuation and/or Portability Privilege benefit, check the box next to the coverages for which you are currently insured and wish to continue. Not checking a box will be considered a declination of the Continuation and/or Portability Privilege benefit. Voluntary Dependent Term Life Insurance coverage can only be continued when the Employee's Voluntary Term Life Insurance is continued.

☐ Basic Life ☐ Voluntary Dependent Life / AD&D
☐ Voluntary Life / AD&D ☐ Supplemental Term Life

Have you smoked cigarettes or cigars, used a pipe or smokeless tobacco, or chewed tobacco in the past 12 months?
☐ Yes ☐ No

Dependents for which you are applying to continue the coverage under the Continuation and/or Portability Privilege in the Group Voluntary Term Life Insurance contract: (Only complete this section if dependent was insured at the time coverage terminated.)

Name	Relationship	Date of Birth	Full Time Student	Disabled
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Have any of the above dependents smoked cigarettes or cigars, used a pipe or smokeless tobacco, or chewed tobacco in the past 12 months? ☐ Yes ☐ No If "Yes", list those individuals: _____

If applying for the Continuation and/or Portability Privilege, please complete the beneficiary designation below:

PRIMARY BENEFICIARY(S)

Name	*Relationship*	*Address*	*DOB*	*SSN*	*Percentage*
				Total[1]	

CONTINGENT BENEFICIARY(S) IF THE PRIMARY BENEFICIARY(S) PREDECEASES YOU

Name	*Relationship*	*Address*	*DOB*	*SSN*	*Percentage*
				Total[1]	

This beneficiary designation supersedes and cancels all prior beneficiary designations by the insured person.

Lack of Notice of Community Property Interest: If AUL has not previously received written notice of a community property interest and if the space for consent below is not signed by a person having such an interest, then AUL shall be entitled to rely upon its good faith that no such interest exists.

Spouse's signature and consent *(if applicable)*:[2] _____ Date _____

[1] Total percentage must equal 100%. If percentages do not equal 100%, then benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, benefits will be distributed equally.

[2] Spouse's signature is needed only if Insured/Beneficiary lives in a community property state which currently include AZ, CA, ID, LA, NM, NV, TX, WA and WI.

Please remember to sign Employee Section page 3 and keep a copy for your records.

Section I – TO BE COMPLETED BY EMPLOYEE (continued)

Employee Name: _____ Employer Name: _____

3. Conversion Privilege of Long Term Disability Insurance

Please consult your Long Term Disability policy to determine if it contains a Conversion Privilege. **If there is no Conversion Privilege in the policy, please skip to number 4.** If the policy contains a Conversion Privilege, eligible insureds may be eligible to continue coverage under the policy after employment ends by paying premium directly to AUL.

If you wish to begin the application process to convert the LTD coverage, check the following box. Not checking the box will be considered a declination of the Conversion Privilege benefit.

☐ Traditional Long Term Disability

4. Portability Privilege of Disability Insurance

If coverage under the Group Voluntary Disability, Group Worksite or Lump Sum Disability insurance contract terminates, eligible insureds can apply to continue the coverage through the Portability Privilege and pay premiums directly to AUL.

If you wish to begin the application process to continue coverage, select each coverage you wish to continue. Not checking a box will be considered a declination of the Portability Privilege benefit.

☐ Voluntary Short Term Disability ☐ Voluntary Long Term Disability ☐ Lump Sum Disability
☐ Worksite Disability

- I hereby apply to AUL to continue or convert the insurance coverage for which I am eligible and which is available under the group life and/or disability insurance contract issued by AUL. I represent that any information or documents I provide to AUL prior to and after the date of the application to continue or convert insurance and any facts and other matters contained in this application are true and accurate to the best of my knowledge and belief. I understand and agree that any insurance, which shall be continued or converted, is contingent upon any statements made to AUL as being complete and correct.
- I understand premium payment greater than the amount of premium owed will not result in additional coverage under the contract.
- I understand no continuation or conversion of coverage under any contract will be effective until this application is received, reviewed, and approved in writing by AUL. If no coverage is issued and/or approved, I understand the premium deposit will be refunded.
- I understand and agree that any dependent who was previously excluded from coverage is not eligible for Continuation of Coverage of life insurance.
- I understand the ability to continue coverage under the contract is contingent upon, but is not limited to, the following conditions:
  1) I must remit required amount of premium plus any administration fee directly to AUL, within 31 days of the date my coverage terminated; and
  2) Failure to pay the correct amount of premium timely will terminate the insurance under the contract at the end of the period for which the premium has been paid.
- I understand and agree any coverage or benefit under any contract will be approved only if AUL decides in its discretion that I am entitled to it. I have read, understood, and retained for my records the notices, limitations, and exclusions.

Signature of Employee: _____ Date: _____

Please sign and keep a copy for your records.

Application to Continue/Port or Convert Group Insurance

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 368
Indianapolis, IN 46206
1-800-553-5318
Fax: 1-888-285-7542
www.employeebenefits.aul.com

OneAmerica®

Section II – TO BE COMPLETED BY EMPLOYER
Please attach copies of the Group Enrollment Form(s), GIB Election Form(s) and/or Life Event Benefit Form(s).

Policyholder Name: _____ Policyholder Number: _____

Employee Name: _____

Employee Full Time Hire Date: _____ Number of Hours Worked Per Week: _____

Effective Date of Employee Insurance: _____ Was Evidence of Insurability Required? ☐ Yes ☐ No

If benefit is based on a multiple of salary, please complete this section.

Annual Salary (prior to the employee's last date worked)	Please Indicate How the Employee is Paid (check all that apply)
$ _____	☐ Hourly ☐ Salaried ☐ Other _____ ☐ Includes Commissions ☐ Includes Bonuses

Date Employee was Last Physically/Actively at Work: _____

Employee Occupation: _____

Date through which premiums are paid: _____

Date Employee was given Application to Continue/Port or Convert Group Insurance: _____

Is/was the Employee on an approved Leave of Absence: ☐ Yes ☐ No

If Yes, what type of Leave of Absence: _____

_____

Indicate reason for coverage termination

For Life Insurance Coverage:

☐ 1. Termination of contract and coverage has not or will not be obtained with another carrier within 31 days
☐ 2. Termination of Employment
☐ 3. Reduction of Hours Date: _____
☐ 4. Reduction of Life Insurance Amount
☐ 5. Divorce from Insured Date: _____
☐ 6. Layoff ☐ Permanent ☐ Temporary
☐ 7. Death of Insured
☐ 8. Attainment of Limiting Age (Employee)
☐ 9. Attainment of Limiting Age (Spouse)
☐ 10. Attainment of Limiting Age, Full Time Employment or Marriage of Dependent Child Date: _____
☐ 11. Retirement: Date of Retirement _____
☐ 12. Disability: Date of Disability _____
☐ 13. Enter Active Military Service: Date Entered _____
☐ 14. Other: _____

For Disability Insurance Coverage:

☐ 1. Termination of contract and coverage has not or will not be obtained with another carrier within 31 days
☐ 2. Termination of Employment
☐ 3. Reduction of Hours
☐ 4. Retirement: Date of Retirement _____
☐ 5. Enter Active Military Service: Date Entered _____
☐ 6. Layoff ☐ Permanent ☐ Temporary
☐ 7. Disability: Date of Disability _____
☐ 8. Other: _____

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Section II – TO BE COMPLETED BY EMPLOYER (continued)

Employee Name: _____ Policyholder Name/Number: _____

Identify all existing coverages and amounts of those coverages:

☐ Basic Term Life	Class _____	Volume _____	
☐ Basic Dependent Term Life			
Spouse	Class _____	Volume _____	Plan # _____
Child	Class _____	Volume _____	Plan # _____
☐ Voluntary Term Life	Class _____	Volume _____	Plan # _____
☐ Voluntary AD&D	Class _____	Volume _____	Plan # _____
☐ Voluntary Dependent Life			
Spouse	Class _____	Volume _____	Plan # _____
Child	Class _____	Volume _____	Plan # _____
☐ Voluntary Dependent AD&D			
Spouse	Class _____	Volume _____	Plan # _____
Child	Class _____	Volume _____	Plan # _____
☐ Supplemental Life	Class _____	Volume _____	Plan # _____
☐ Traditional Long Term Disability	Class _____		Plan # _____
☐ Voluntary Short Term Disability	Class _____		Plan # _____
☐ Voluntary Long Term Disability	Class _____		Plan # _____
☐ Lump Sum Disability	Class _____	Benefit Amount _____	Plan # _____
☐ Worksite Disability	Class _____	Benefit Amount _____	Plan # _____

The undersigned represents that any information or documents provided to AUL prior to and after the date of the application for insurance and any facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief.

The undersigned understands and agrees:

1) any insurance coverage or benefit is contingent upon any statement made to AUL as being complete and correct; and
2) benefits under any policy will be paid only if AUL decides in its discretion the applicant is entitled to them.

The undersigned has read, understood, and retained for the company's records the notices, limitations, and exclusions.

Signed By: _____ Date: _____

Title: _____ Phone Number: _____

Email Address: _____

Fraud Warnings *(For use in AL, AR, DC, LA, NM, TX and WV)*
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Alabama
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska
A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona
For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California
For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment or fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or reward payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware, Idaho, Indiana, Oklahoma
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida
Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky
Any person who knowingly and with intent to defraud any insurance company or other person files a statement of a claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Washington
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland, Rhode Island
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire, Ohio
Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.

New Jersey
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or any other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Virginia
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Allstate Benefits

American Heritage Life Insurance Company
Allstate Benefits
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Telephone 1-800-521-3535
Facsimile 866-428-2516
www.allstateatwork.com

Premium and Billing Change Request

Policy Number(s) _____ **Owner's Name** _____

Policy Owner Mailing Address _____
(Street) (Apt)

_____
(City) (State) (Zip)

Agent Name and Number _____

Agent Use Only – subject to AHL rules, send all items to be returned to: ❑ Agent ❑ Owner

❑ **1. Pre-authorized Check Plan (PAC)**

Account Holder's Name: _____ Phone: (____) _____

Address: _____ City: _____ State: ____ Zip: _____

Name of Financial Institution: _____

Branch Address: _____

❑ Savings

ACH/Routing Number: _____ Account Number: _____ ❑ Checking

For saving accounts attach bank document account verification
For checking accounts attach voided check

Please choose the day of the month for the deductions: _____ (Choose any day 1 – 28)

Deductions will be made ❑ Monthly ❑ Semi-Annually ❑ Annually for the following policies:

Policy Number	Policyholder Name	Premium Amount

Total Deduction: $0.00

If account holder is different from policy owner, please describe relationship: _____

I authorize American Heritage Life Insurance Company ("AHL") to initiate debit entries electronically to my account, and in the amount and frequency, indicated above and I authorize the financial institution named above to debit same to such account. This authorization remains effective and in full force until AHL and the financial institution have received written notification from me of its termination in such time and in such manner to afford AHL and the financial institution a reasonable opportunity to act on it.

Account Holder's Signature: _____ Date: _____

❑ **2. Request to Cancel** *(Health policies only; if requesting to cancel a life insurance policy a separate form is required. If your premiums are payroll deducted you may be subject to IRS Section 125 rules.)*

❑ **3. Change Payment Method to Direct Billing**

❑ **4. Change Payment Method to Coupon Billing**

❑ **5. Change Bank Account Number from** _____ **to** _____

Please sign below when requesting options 2 - 5. Thank you.

Owner's Signature: _____ Date: _____

TEXAS **LIFE** INSURANCE COMPANY
A MetLife® Company

Automatic Bank Draft Form

A convenient payment option for you...

Three Easy Steps:

1. Read and complete each item on the Automatic Bank Draft Form.
2. Include either a voided check or deposit slip as required.
3. Include any payments due.

Please enter all Texas Life policy numbers you want drafted with this authorization: _____

_____

Enter the day of the month you want premiums drafted (1st - 28th). Date cannot be more than 15 days after due date:_____

Texas Life will begin drafting your account for the current or any outstanding premiums due immediately, unless you indicate a different start date here: _____

Please check the appropriate box:

[ ] **Checking Account**	Include a check with "Void" written on it.
[ ] **Savings Account**	Include a deposit slip with "Void" written on it.
[ ] **Resume the Draft**	Draft will continue with current information on file.

Work Number (_____)_____Home Number (_____)_____Mobile Number (_____)_____

Drafts are submitted to the bank on the day you 've chosen above, and should clear your account within 2 - 3 days. If your draft date falls on a weekend or holiday, it will leave our office on the next business day.

As a convenience to me, I hereby request and authorize you to pay and charge to my account drafts drawn on my account by and payable to the Texas Life Insurance Company, Waco, Texas provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such draft shall be the same as if it were a draft drawn on you and signed personally by me. The payment of premium under this plan may be discontinued by the Company or the undersigned. You shall be under no obligation to determine the correctness of the amount of any draft drawn under this authority. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. For the purpose of this form, a facsimile copy of my signature shall be as valid as an original. (Fax 254-745-6393)

_____ _____

Signature of Bank Account Holder **Date**

061016