Individual Automatic Premium Collection Agreement and Authorization

COMBINED INSURANCE®

Company Name: _____

Employee Name: _____

Email: _____ **Phone:** _____

I, the individual who is signing below, hereby authorize Combined Insurance Company of America ("Combined"), to initiate electronic debit entries or to effect a change by any other commercially accepted method, to my checking account (as shown below) in the financial institution named below (hereinafter called Depository). I specifically authorize Depository to debit my account on a monthly basis to pay premiums for the insurance for which I have applied today. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination. I understand that such notification from me must be given with sufficient time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I also authorize Combined to change the amount of my debit: (1) to correct clerical errors in the initial premium calculation for the above selected coverage(s) and (2) to reflect changes in premium resulting from Combined's underwriting actions, any changes in coverage I may request, and any automatic premium increase that may be required under the terms of my policy(ies). These changes in the amount of my debit are to be made only at the direction of Combined and such change(s) does not require any other subsequent or additional authorization by me.

I understand that if premiums are not paid within the grace period under the subject policy(ies) or certificate(s), as in the event withdrawals are dishonored, the policy(ies) or certificate(s) will terminate. However, certain life insurance policies may contain non-forfeiture provisions and/or automatic premium loan provisions, which may extend coverage for a period of time. The specific provisions of each policy will govern.

Depositor Name: _____
(Please Print)

Depositor Signature: _____ _____
(Signature must be the same as on file at the bank/financial institution.) (Date)

Preferred draft date of each month: ☐ Draft Amount $ ☐

TYPE OF COVERAGE	POLICY/CERTIFICATE NUMBER

Complete the information below or attach a voided check.

Name of Bank

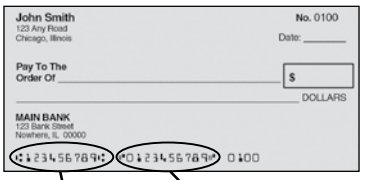
City & State of Bank

Routing (ABA) Number (9 digits)

Account Number

Account Type

☒ Checking



Combined Insurance Company of America | 8750 W. Bryn Mawr Ave. | Chicago, IL 60631 | Ph. 800-544-9382 | Fax 872-304-6032

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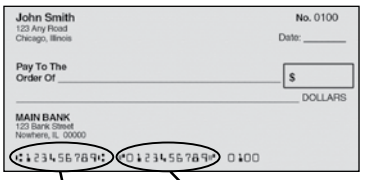

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