



Central States Health & Life Co. of Omaha

P.O. Box 4574 • Houston, TX 77210-4574  
1-800-541-2363 Fax: 1-281-368-7148

Administered by Philadelphia American Life Insurance Company

**Request for Electronic Funds Transfer**

*Note: This form allows your financial institution to pay the premiums for you automatically.*

**As a convenience to me, I authorize Philadelphia American Life Insurance Company on behalf of Central States Health & Life Co. of Omaha to withdraw funds from my account by check, draft, or automatic debit entry at the financial institution named below.**

**It is agreed that:**

- 1) This agreement shall in no way alter or amend the provisions of this policy except that the Company shall not be required to give notice of premium due as long as this agreement is in effect.
- 2) The Company shall not incur any liability by reason of dishonor of any check, draft, or debit entry.
- 3) This authorization is to remain in effect until you receive notice from me to revoke it.
- 4) No payment or portion thereof shall be deemed paid unless the Company receives actual payment at its Home Office.

Please complete the following information as it applies to your request for Electronic Funds Transfer:

Depositor's Name (if other than Insured or Policyowner) \_\_\_\_\_  
If a company account, the name of the account must be shown

Financial Institution \_\_\_\_\_

Routing Number \_\_\_\_\_

Account Number \_\_\_\_\_

Policy Owner Name \_\_\_\_\_

Policy Owner Address \_\_\_\_\_

Street

City

State

Zip

Check here if this is a new address

Withdraw from my account:

Monthly       Quarterly       Semi-annually       Annually

INSURED'S NAME	POLICY NUMBER

**X** \_\_\_\_\_  
Authorized Signature as Shown on Account

\_\_\_\_\_  
Date

TO PROTECT YOUR VALUABLE COVERAGE, PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGE OF ADDRESS OR CHANGE OF FINANCIAL INSTITUTION OR ACCOUNT INFORMATION

**SEND THIS FORM AND A VOIDED CHECK TO US.**

EFT.CSO.HOU