## BANKERS LIFE AND CASUALTY COMPANY'S Automatic Banking by Choice Plan – A convenient service for you



I hereby request and authorize you to honor and change the deductions drawn on my account by and payable to the Company indicated on the reverse side. The signatures on such deductions may be either typed or printed. If any such deductions are dishonored, either with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture in insurance.

This authorization shall continue in force until revoked by me in writing and received by you, a copy of which revocation shall be sent by me to the Company, at the Administration Office in Carmel, IN. I shall allow seven (7) to ten (10) business days from the date my written notarization is received in your office before you can guarantee my deduction will be canceled. The Company has instructed me to forward this authorization to you, the Company.

I request that such deduction	s be drawn on my account o	on the	day of the month (excluding the	29th, 30 <sup>th</sup> , and 31 <sup>st</sup> .)	
·	PLEASE ATTACH		ECK MARKED "VOID"	,	
(1) Complete the below	(2) Attach a voided c	·	Return to the Company or sub Premium Admir 312-324-5060		
	Yes! I'd like to start pa	ying my premiun	ns via Bankers' ABC Plan.		
☐ Bank Account		☐ Credit Union Account			
Name of bank or credit union			144-4-4-2-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-		
Address of bank or credit unio	วท				
City		State	Zip		
Bank Transit/Routing No.		Account No.			
Checking Account (Attach *If savings is selected, please inc account.	• • •		☐ Savings Account * uting number and any special instr	uctions for drafting from your	
Payment Plan Withdrawal of			ment to be withdrawn. Choose any he date will default to the monthly p		
Frequency of Payment:	Monthly	Quarterly	Semiannually 🗌 Annual	lly	
Amount*		*This field is f	or annuity policies only.		
Policy No. 1		Insured's Name			
Policy No. 2		Insured's Na	Insured's Name		
As a convenience to me, I hereby account and drawn by Bankers Li same upon presentation, I agree to by me. I hereby agree that if any otherwise, you shall be under no I	request and authorize you to in fe and Casualty company, Carr that your rights in respect to sud debit is not paid by me for any liability whatsoever, even thoug d by me upon 30 days advance	nitiate debit entries, v mel, Indiana, provider ch debits shall be the reason with or withou th such nonpayment	natic Banking by Choice (ABC) whether by electronic or paper meal d there are sufficient collected fund same as if they were a check draw at cause or whether such nonpaym results in the forfeiture of insurance until you have actually received such	ns, with these debits made to my is in that account to pay the vn on you and signed personally ent is intentional, inadvertent or this authorization is to remain	
Date	Name of depositor (p	lease print)	Signature of depositor		

## INDEMNIFICATION AGREEMENT

Bankers Life and Casualty Company (hereinafter referred to as "Company") is hereby authorized to make withdrawals from my account including checks, drafts or electronic fund transfers, payable to Company, pursuant to the accompanying or previously executed Agreement with the Company for the purchase of mutual fund shares and/or payment of premiums for insurance or annuity contract issue by Company. It is hereby agreed that: (1) The withdrawals reflected on my bank account will constitute receipts. (2) The plan may be revoked by the company without prior notice if any account withdrawal is not paid upon presentation. The company shall be under no obligation to notify the undersigned as to non-payment of any account withdrawal. (3) The Plan is not a modification of any of the provisions of the Agreement between the Company and the undersigned. (4) This Plan may be discontinued by the Company upon thirty (30) days written notice to the owner indicated in the Agreement.



## Dear Valued Customer:

Thank you for the opportunity to serve your insurance needs.

Attached you will find the Pre-Authorized Checking (PAC) Form you requested with instructions to assist you. Please return the voided check and the completed form to the PAC Form Return Address indicated for your company below, or use the fax number shown on the PAC form. Please indicate your policy number on the attachment. A return envelope is enclosed for your convenience.

We want to assure you of the continued commitment to provide you with the best possible service. If we may be of any further assistance, please contact us.

Sincerely, Customer Service Department

RETURN ADDRESSES FOR COMPLETED PAC FORMS: BANKERS LIFE AND CASUALTY COMPANY Home Office: P.O. Box 1938 Carmel, IN 46082-1938