Sagicor Life Insurance Company
4343 N. Scottsdale Rd., Suite 300
Scottsdale, Arizona 85251
(888) 724-4267 / Fax: (480) 425-5139

AUTHORIZATION TO ADD OR CHANGE ELECTRONIC FUNDS TRANSFER (EFT)

OWNER AND PAYOR INFORMATION

Name of Owner (First, Middle, Last)	Name of Payor (If different from Owner)	Policy Number(s)

Payor Address	Payor SSN or Tax ID	Payor DOB

TYPE OF REQUEST

Unless otherwise noted, complete this section and the Authorization and Acceptance section below.

- ☐ Change withdrawal amount to: $
- ☐ Add to existing EFT under policy number:
- ☐ Change the withdrawal day of the month to (1st – 28th only):
- ☐ Change the withdrawal mode to: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually
- ☐ Please allow a supplementary draft(s) of my account, other than the scheduled draft, to bring my policy(ies) current.
- ☐ Change from direct billing to EFT: *Please complete ALL sections below*.
  Withdrawal day of the month (1st – 28th only): ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually
- ☐ Change of bank and/or account number: *Please complete ALL sections below*.
  Withdrawal day of the month (1st – 28th only): ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

PAYOR'S ACCOUNT INFORMATION

Bank or Financial Institution Name:	Name of Account Owner:
Routing Number:	Account Number:

Account Type:

- ☐ Checking (Please include a voided check or a letter from the bank with your routing & account number. Not required if the Payor's Account Information above is complete and accurate.)
- ☐ Saving (Please attach a letter from the bank with your routing & account number. A deposit slip does not provide the information required and is not acceptable.)

NOTE: Debit and Credit Card account numbers are not acceptable.

AUTHORIZATION AND ACCEPTANCE

(Required for all requests)

I hereby request and authorize Sagicor Life Insurance Company (Sagicor) to make electronic funds transfers from my bank or financial institution as indicated above. This authorization will remain in effect until revoked by me or by Sagicor upon thirty (30) days written notice. I understand that if a fund transfer is not honored by the financial institution, Sagicor will consider the premium unpaid. Any fund transfer returned due to insufficient funds may be re-drafted by Sagicor at its sole discretion. I further agree that if any such fund transfer is not honored, whether with or without cause, Sagicor shall be under no liability whatsoever, even though such dishonor results in the lapse of insurance.

Sagicor reserves the right to revoke this authorization without notice. If this authorization is revoked by Sagicor, it is not eligible to be reinstated for a twelve (12) month period. You must contact Sagicor and request that this authorization be reinstated.

Payor/Bank Account Owner Signature	Date

ATTACH A VOIDED CHECK