Monumental Life Insurance Company
Transamerica Advisors Life Insurance Company
Transamerica Advisors Life Insurance Company of New York
Transamerica Financial Life Insurance Company
Transamerica Life Insurance Company
Western Reserve Life Assurance Co. of Ohio

AUTOMATIC PAYMENT AUTHORIZATION

Service Office and Overnight Mailing Address:
4333 Edgewood Rd N.E., Cedar Rapids, IA 52499

1. OWNER INFORMATION

Name

Address

City, State, Zip

Telephone Number | Social Security Number

❑ Existing Policy Number: ______________________ ❑ New Policy*

*The owner must have paid the minimum initial payment required to issue the contract before Automatic Payment Authorization payments can begin.

NOTE: A voided personal check must accompany the Automatic Payment Authorization Application.

2. REQUIRED SIGNATURE SECTION

As a convenience to me, I request and authorize the Insurance Company to obtain payment of amounts becoming due to the Insurance Company by initiating charges to my account in the form of checks, share drafts or electronic debit entries, and I request and authorize the financial institution named below to accept and honor the same and to charge the same to my account. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect not to receive notice if such entry is equal to the amount due the Insurance Company. This Authorization will remain in effect until I notify the Insurance Company or the financial institution, in writing, to terminate this Authorization, and the Insurance Company or the financial institution has a reasonable time to act on the termination. I hereby terminate any prior Authorization of the Insurance Company to initiate charges to this account, effective the date on which the initial charge is initiated by the Insurance Company under this Authorization. I understand that I may stop any charge by notifying the financial institution before my account is charged, and I may have the amount of the erroneous electronic debit entry credited to my account within 15 days after issuance of my statement or 45 days after posting, whichever occurs first. I acknowledge receipt of a copy of this Authorization.

Name of Financial Institution Where Account is Authorized

Address of Financial Institution

City, State, Zip

☞

Signature of Depositor | Date

2. REQUIRED SIGNATURE SECTION (CONTINUED)

ATTACH VOIDED CHECK HERE

All Policy Numbers Affected (if already issued)

Financial Institution Transit Number | Depositor's Account Number

Debit Frequency: ❑ Monthly on the ______________ (1st - 25th of the month) ❑ Quarterly Beginning ______________ (Month/Day (1st - 25th of the month))

Dollar Amount to be Deducted from your: Checking Account: $ ____________ or Savings Account: $ ____________
($50 Minimum Per Draft)

Date Deduction to Begin | ☞ Signature of Depositor

3. FINANCIAL INSTITUTION INSTRUCTIONS

So that you may comply with your depositor's request, the Insurance Company agrees:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, share draft or electronic debit entry, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment (under this plan), including any costs or expenses reasonably incurred in connection therewith.
- To indemnify you for any loss, in the event that any such check, share draft or debit entry shall be dishonored whether with or without cause, and whether intentionally or inadvertently, even though dishonor results in forfeiture of insurance or other right.
- To defend at our own cost and expense, any action which might be brought by any depositor or any other person because of your actions taken pursuant to the foregoing request, or in any manner arising by reason of your participation in the foregoing plan of payment collection.