



(Hereafter referred to as the Company, we, our or us)

Automatic Payment Authorization

The following Transamerica Companies utilize this form:

- Transamerica Advisor Life Insurance Company
- Transamerica Financial Life Insurance Company
- Transamerica Life Insurance Company
- Transamerica Premier Life Insurance Company

4333 Edgewood Rd NE, Cedar Rapids, IA 52499
 Fax: (877) 355-4385
 Website: www.transamerica.com

The Automatic Payment Authorization option is not available for Custodially-Owned policies.

POLICY INFORMATION

Policy Owner: _____ Policy Number: _____

Joint Owner (if applicable): _____

Citizenship/Jurisdiction: U.S. Citizen * U.S. Territory * (_____) Non-U.S. Citizen * (_____)

(Territory) (Country)

Resident Alien Non-Resident Alien

* Not providing citizenship may delay processing.

ACCOUNT INFORMATION

The process date must be between the 1st and the 28th day of the month. Please allow additional processing time from receipt of request. If the Automatic Payment Authorization is received after the requested date, changes will be effective on the next scheduled draft date.

NEW ACCOUNT SETUP

Name(s) on Account _____

Financial Institution Name _____

Financial Institution Address _____

City, State, Zip _____

Routing Number _____

Account Number _____

Amount to be Deducted: \$ _____ Date Deduction to Begin: ⁽¹⁾ _____

Account Type: ⁽²⁾ Savings Account Checking Account (\$50 Minimum Per Draft)

Debit Frequency: Bi-Weekly Monthly Quarterly Semi-Annually Annually

Please Note: If the account information written above differs from the supporting documentation provided, the Company will use the information on the supporting documentation. Please review the Financial Institution Information section for specifics on the supporting documents to provide.

(1) If not marked, the Company will default to the 1st of the month.

(2) If not marked, the Company will default to checking.

CHANGE TO EXISTING ACCOUNT

- On the next scheduled draft date
- Change the scheduled draft date: ⁽¹⁾ _____

Name(s) on Account

Financial Institution Name

Financial Institution Address

City, State, Zip

Routing Number

Account Number

Amount to be Deducted: \$ _____

Account Type: ⁽²⁾ Savings Account Checking Account (\$50 Minimum Per Draft)

Debit Frequency: Bi-Weekly Monthly Quarterly Semi-Annually Annually

Please Note: If the account information written above differs from the supporting documentation provided, the Company will use the information on the supporting documentation. Please review the Financial Institution Information section for specifics on the supporting documents to provide.

- (1) If neither option is selected, the Company will default to the next scheduled draft date.
- (2) If not marked, the Company will default to checking.

FINANCIAL INSTITUTION INFORMATION

In order for the Financial Institution to comply with the Depositor's request to allow the Company to obtain payments of amounts becoming due to the Company by initiating charges to the Depositor's account held at the Financial Institution, the Company agrees:

- To indemnify the Financial Institution for any loss the Financial Institution incurs as a direct consequence of complying with the Depositor's request as described in this Section.
- To defend, at the Company's own cost and expense, any action brought by the Depositor or any other person against the Financial Institution as a direct consequence of the Financial Institution complying with the Depositor's request as described in this Section.

Attach Savings Deposit Slip or Voided Check here.

The Company reserves the right to request additional documentation from the Depositor.

- **If the automatic payment is to be paid from an Entity or Trust account, the Company requires a Letter of Instruction, indicating who can sign for the account, on Financial Institution letterhead signed by an Officer of the Financial Institution.**

ACKNOWLEDGEMENTS AND REQUIRED SIGNATURE

As a convenience to me, as Depositor, I request and authorize the Company to obtain payment of amounts becoming due to the 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 to accept and honor the same and to charge the same to my account.

I understand 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 to the Company. This Authorization will remain in effect until I notify the Company or the Financial Institution, in writing, to terminate this Authorization, and the Company or the Financial Institution has a reasonable time to act on the termination.

I hereby terminate any prior Authorization of the Company to initiate charges to this account, effective the date on which the initial charge is initiated by the Company under this Authorization. I understand I may stop any charge by notifying the Financial Institution before my account is charged, and I may have the amount of the electronic debit entry credited to my account within 15 days after issuance of my statement or 45 days after posting, whichever occurs first.

Printed Depositor's Authorized Representative Name (Printed name is required for Entity or Trust accounts.)

Signature of Depositor

Date

Depositor's Telephone Number