



**Sagicor Life Insurance Company**  
 8660 E. Hartford Drive, Suite 200  
 Scottsdale, AZ 85255-2583  
 (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.*

<input type="checkbox"/> Change withdrawal amount to: \$	<input type="checkbox"/> Add to existing EFT under policy number:
<input type="checkbox"/> Change the withdrawal day of the month to (1 <sup>st</sup> – 28 <sup>th</sup> only):	
<input type="checkbox"/> Change the withdrawal mode to: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	
<input type="checkbox"/> Please allow a supplementary draft(s) of my account, other than the scheduled draft, to bring my policy(ies) current.	
<input type="checkbox"/> Change from direct billing to EFT: <i>Please complete ALL sections below.</i>	
Withdrawal day of the month (1 <sup>st</sup> – 28 <sup>th</sup> only): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	
<input type="checkbox"/> Change of bank and/or account number: <i>Please complete ALL sections below.</i>	
Withdrawal day of the month (1 <sup>st</sup> – 28 <sup>th</sup> only): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> 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
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### VOIDED CHECK or BANK VERIFICATION ATTACHED

NAME ADDRESS CITY, STATE, ZIP	DATE _____	9999 01-23456789
PAY TO THE ORDER OF _____	\$ _____	DOLLARS
<b>SAMPLE</b>		
BANK NAME ADDRESS CITY, STATE, ZIP MEMO _____	:159736428 : 01020304050607 9999 Bank Routing Number Bank Account Number Check Number	

