ACH Debit Authorization / Standing Authorization for Life Policies

American National / One Moody Plaza, Galveston, TX 77550-7947

Overnight Address

Career Sales and Service Division: Mailing Processing Center, Attn: CSSD, LPA 4448, 1949 E. Sunshine St. Springfield, MO 65899-0001 / **Phone** 1-800-899-6806

Life Insurance Services: Mailing Processing Center, Attn: LIS 3257, 1949 E. Sunshine St. Springfield, MO 65899-0001 / **Phone** 1-800-899-6806

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Mailing Address

Career Sales and Service Division: Mailing Processing Center, P.O. Box 4448, Springfield, MO 65808-4448

Life Insurance Services: Mailing Processing Center, P.O. Box 3257, Springfield, MO 65808-3257

1 Company Selection

- ☐ American National Insurance Company
- ☐ American National Life Insurance Company of Texas
- ☐ Garden State Life Insurance Company
- ☐ American National Life Insurance Company of New York
- ☐ Standard Life and Accident Insurance Company

2 Policy Information

Policy Number	Policy Owner	Insured
Policy Number	Policy Owner	Insured
Policy Number	Policy Owner	Insured
Policy Number	Policy Owner	Insured

Agent Name (optional)

3 Recurring Payments

☐ Life and Whole Life

Withdrawal Amount:
(Please refer to the schedule of premiums in the data section of your policy. The withdrawal amount may change as outlined in your contract, or with contract changes.)

Withdrawal Date: _____

Withdrawal Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ Universal Life and Indexed Universal Life

Withdrawal Amount: _____

Withdrawal Date: _____

Withdrawal Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ Loan Payments (if policy or contract has an outstanding loan, and the premium is on automatic withdrawal)

Withdrawal Amount: _____

(The minimum loan payment amount is $15 unless your contract specifies a different amount.)

Withdrawal Date:

☐ I acknowledge the loan payment withdrawal date will be the same as the premium withdrawal date.

Withdrawal Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ Multiple Policies Debited as a Single Withdrawal Amount

The single withdrawal billing option is available for policies issued by the same Company. It is not available for variable life policies or annuities.

4 One-Time Payment

Withdrawal Amount
$_____

Withdrawal Date
_____

5 Standing Authorization

I may request that the Company initiate a one-time payment using the bank account information below by contacting the Company at the phone numbers listed above.

6 Authorization

I hereby authorize the selected company and its affiliates (the "Company") to electronically debit my account (and if necessary to electronically credit or debit my account to correct erroneous transactions) in accordance with the selections above to pay premiums and other charges for the listed insurance policies and annuity contracts. I agree that ACH transactions I authorize must comply with applicable law, and I agree to comply with National Automated Clearing House (Nacha) rules and regulations about electronic transfers. I also agree to maintain an adequate balance in my account to cover my insurance premiums and other charges. The Company will not be liable for any bank service fees charged against the account.

If no withdrawal date is specified, the withdrawal date will be the day of the issue date of the contract. If the withdrawal date falls on a weekend, holiday, or date that does not exist, the withdrawal will occur on the next banking day. The Company will give written notice to the policy owner, and if different, the bank account owner of any increase in the withdrawal amount 10 days in advance or as otherwise required by law. I do not require advance notice of any decrease in the withdrawal amount. If the withdrawal amount decreases, the new amount will be withdrawn at the next scheduled date, and the Company will notify the policy owner, and if different, the bank account owner, in writing of the decrease.

Except as specified in Section 7 below, I understand that this authorization will remain in full force and effect until I revoke the authorization in writing to the mailing address at the top of this form. The Company requires at least 10 days advance written notice to process revocation. The Company reserves the right to cancel this authorization at any time. The Company may amend this authorization at any time by giving 30 days advance written notice.

7 Return for Insufficient Funds or Invalid Bank Account

I understand and agree that:

1. All debits are accepted by the Company subject to their being honored upon presentation.
2. If the funds in my account are insufficient to pay a debit:
- **a.** The Company will notify the policy owner, and if different, the bank account owner.
- **b.** The Company reserves the right, at the next available opportunity, to resubmit the withdrawal amount for presentation against the designated bank account; however, the Company is not required to do so.
- **c.** For term life, whole life, and health, the Company will suspend the pre-authorized payment privilege until the premium is paid current.
- **d.** For universal life, variable life, and annuities, the Company will discontinue the pre-authorized payment privilege until it receives a new authorization.

3. If the account is invalid, the Company will discontinue the pre-authorized payment privilege until it receives a new authorization.
4. If a payment is not made when due, the payment status and duration of the policy or contract will be governed by the contract terms for insufficient payment.

8 Bank Account Information

☐ Checking ☐ Savings

Bank or Depository Institution

Branch

Account Number
#

Routing Number
#

City

State

ZIP

9 Bank Account Owner Information

First Name

M.I.

Last Name or Non-Natural Entity Name

Mailing Address

City

State

ZIP

Telephone

Bank Account Owner Relationship to Policy Owner

Email Address

10 State Specific Fraud Language

For California Residents:

For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

11 Signature

x

Signature of Bank Account Owner

Date: Month / Day / Year

ATTACH YOUR VOIDED CHECK (OPTIONAL)

This is encouraged to ensure the accuracy of your banking information.