PAYROLL DEDUCTION FORM

Loyal American Life Insurance Company®

Please complete this form and fax **with the completed applications** to: (512) 467-7403 Attn: Case Coordinator

Employee Authorization for Deduction of Premiums from Salary: I hereby request that you deduct from my salary and forward to Loyal American Life Insurance Company the appropriate premium. Such deductions will cease upon (1) termination of my employment, (2) written notice by me requesting that deductions cease and stating when such cancellation is to be effective*, (3) termination of this payroll deduction plan, or (4) written notice from Loyal American Life Insurance Company.

I understand that premium deduction amounts may change and do hereby consent to such changes without the necessity of additional authorization of my part, verbal or written, provided that the insurance company above certifies in writing that the changes in premium uniformly affect all members of the class to which I belong.

INFORMATION			
Date:	Employee SSN #:		
Employee's Name (print):			
Spouse's Name (if applicable):			
Approximate Monthly Premium:	Employee $	Spouse $	Total $
Employee's Signature:			