ILLINOIS MUTUAL®
Life Insurance Company
300 S W Adams Street Peoria, IL 61634
800 437 7355

Authorization for Monthly EFT

I, the Account Holder, authorize Illinois Mutual ("YOU") to initiate withdrawal entries to the deposit account designated on this form at the financial institution named below, using the Automated Clearing House for payments due under the policy.

By signing, I agree as follows:

1) The origination of electronic withdrawals to my account must comply with the provisions of U.S. law;
2) Any cancellation of this Authorization must be in writing and will not be effective for at least 5 business days after receipt by Illinois Mutual;
3) If my financial institution does not honor this withdrawal request, YOU will regard (i) my premium as unpaid if this Authorization is for payment of premium; (ii) at YOUR sole discretion, YOU may resubmit the withdrawal request for collection; (iii) the coverage may terminate in accordance with the terms of the Policy if any withdrawal is not honored; and (iv) YOU may charge a fee for any return for insufficient funds;
4) If I change financial institutions or accounts and if any payment is past due at the time of the change, YOU will draft my account for any past due payments upon receipt of the Authorization for the new account so long as coverage has not terminated; and,
5) YOU do not assume any responsibility for charges by any financial institutions related to this Authorization.

I further understand that insurance will be effective only as stated in the application/conditional receipt (if any) for insurance and that this Authorization is only for the purpose of effecting electronic funds transfers for payment of such charges as authorized.

Financial Institution: _____

Routing Number: _____

Account Number: _____ ☐ Checking ☐ Savings

Draft on day _____ of each month (Only days 1 through 28 are valid)

Policy Number(s): _____

☐ Check box if address should be changed.
Account Holder's Address: (City, State, Zip) _____

Account Holder's Name: _____

Account Holder's Signature: _____ Date: _____

Joint Account Holder's Name, if applicable: _____

Joint Account Holder's Signature, if applicable: _____ Date: _____

Return to the Financial Services Department with a copy of a voided check.
Email: GenAcctg@IllinoisMutual.com
Fax: (309) 636-0425