



**The Standard Life Insurance Company of New York**  
 P.O. Box 82622 / Lincoln, NE 68501-2622  
 Phone 888-396-8641 Option 1 / Fax 402-467-7332

## Electronic Funds Transfer (EFT) Form

### Request and Authorization for Bank Payment Plan

It's the simplest method of paying your premium. No more checks to write! It's automatic and reliable. We call it electronic funds transfer (EFT for short). It allows for peace of mind however you do business — whether it's online or through the mail.

Online: Groups that receive invoices online, you have the freedom to choose when we debit your account. When you're ready, just visit our website, [standard.com/eservices](http://standard.com/eservices), sign into your secure account and click PAY BILL. We'll draft your premium payment right away.

Mail: Groups that receive their invoices through the mail, just authorize us to debit your account each month and we'll do the rest. It's the forget-proof method of paying your premium.

### Authorized Agreement for Prearranged Payments (Debits)

Group Policy #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Policyholder Contact: \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> New Authorization | <input type="checkbox"/> Change of Account |
| <input type="checkbox"/> Checking Account  | <input type="checkbox"/> Savings Account   |

I hereby authorize The Standard Life Insurance Company of New York to initiate debit entries to the account number listed below, and at the bank named below, herein called BANK, to debit the same to such account. The EFT draft will be monthly, on or about the first day of the coverage period.

Bank Account Number: \_\_\_\_\_ Bank Routing Number (9 digits): \_\_\_\_\_

Bank Name: \_\_\_\_\_

Account Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone Number of Financial Institution: \_\_\_\_\_

**While not required, sending a voided check with this request will help us set up your account accurately.**

This authorization is to remain in full force and in effect until BANK has received written notification of its termination in such time and such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to have the amount of an erroneous debit immediately credited to his/her account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever comes first. Completion of this request will be 10 or 15 business days after receipt. Please continue to remit payment until you are notified.

Name (print): \_\_\_\_\_ Title of Authorized Signer: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Federal Tax ID #: \_\_\_\_\_

***Please keep a copy of this form for your records.***