American Public Life Insurance Company

A member of the American Fidelity Group

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF INSURANCE CLAIM PAYMENTS

I hereby authorize American Public Life Insurance Company (APL) to initiate credit entries, at the Bank named below, for the purpose of receiving APL insurance claim payments, to my account indicated below. I authorize and request the bank named below to accept any credit entries by APL to my account indicated below. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Employee Information

Social Security Number	Name (Last, First, Middle Initial)	Daytime Telephone Number
Address (Street, City, State & Zip Code)		
Employer		

Account Information (PLEASE ATTACH A VOID CHECK OR DEPOSIT SLIP)

Bank Name	Bank Address
Bank ID (first 8 digits of the routing number)	Bank SCD (Self-Checking Digit – last digit of routing number)
Account Number To Credit	Account Type

This authorization is to remain in effect until APL has received written notification from me of its termination to afford APL reasonable opportunity to act on it. APL reserves the right to discontinue your participation in the Direct Deposit of Insurance Claim Payments services at any time at its sole discretion.

NOTE: THIS FORM MUST BE RECEIVED AND PROCESSED BEFORE A PREAUTHORIZED PAYMENT CAN BE MADE.

Signature_____ Date_____