

LIFE INSURANCE COMPANY OF BOSTON & NEW YORK

HOME OFFICE: 60 MAIN STREET, SUITE 4, HAMBURG, NY 14075
SERVICE ADDRESS: PO BOX 219 CANTON, MASSACHUSETTS 02021
TEL (800) 645-2317 FAX (781) 821-4976

RE: Policy #:

Insured:

Dear Policyholder:

Thank you for your interest in our Electronic Funds Transfer (EFT) payment plan. In order to ensure that EFT debits will be drawn from your account we will require the following:

- The EFT Authorization form, on the reverse side, completed for your new account.
- For withdrawals made from a checking account we require a voided check from your new checking account. For withdrawals from a savings account, we require a copy of your bank statement. Be certain to complete the Transit/Routing numbers (check with the bank) and the Account number on the Authorization form as well.
- The account holder's signature on the bottom of the EFT authorization form. This is your authorization to Life Insurance Company of Boston & New York to automatically issue debits to your account. (If this is a joint account, both signatures are required.)
- Please return the above-mentioned items within 10 business days from the date of this letter.
Your request cannot be processed without these requirements. A return envelope is enclosed for your convenience. If you have any questions, please contact our Client Services Department toll free at 1-800-645-2317.



REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN

☐ **New Request**

☐ **Change/Addition**

Policy #

Insured Name:

Policy #

Insured Name:

I hereby request and authorize the Financial Institution indicated below to pay and charge debits to my account drawn by and payable to the order of Life Insurance Company of Boston & New York for the purpose of making said payments listed below.

Preferred Billing Date each month : ☐ 5th ☐ 10th ☐ 15th ☐ 20th ☐ 25th (automatic option if no date is chosen)

☐ Checking (**Attach a voided check**)

☐ Statement Savings * (**Attach a copy of your bank statement**)

* EFT is not available for passbook savings accounts.

Name as shown on Account: _____

Financial Institution Name: _____

Branch Address: _____

Transit/Routing#: _____

Account #: _____

Additional Requests:

☐ In addition to my premium, please deduct \$ _____ to reduce policy loan for policy _____.

Comments: _____

PLEASE NOTE: If you require that your monthly EFT draft be stopped for any reason, Life Insurance Company of Boston & New York must be notified **at least 7 days before** the draft date, otherwise, the Company may not be able to honor your request.

This authority is to remain in full force and effect until Life Insurance Company of Boston & New York has received written notification from me of its termination in such time and in such manner as to afford Life Insurance Company of Boston & New York and your Financial Institution a reasonable opportunity to act on it. I also authorize any future account changes to be made by me via telephone, in lieu of a signed form.

Date

Printed Name as shown on bank records

Signature(s) as shown on bank records

Telephone Number

Printed Name of joint account holder (if applicable)

Signature of joint account holder (if applicable)