Electronic Fund Transfer (EFT)

RESET FORM 1150

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889, Lincoln, NE 68501 / 800-745-1112, Fax 402-467-7335

Premium Mode Monthly EFT

Add to Existing EFT - provide Policy Number and Insured: _____

Withdrawal Date ____/____ (The withdrawal date must be on or before the policy date and cannot be after the 28th)
Month / Day

Policy Number / Product Applied for	Print Name of Insured	Monthly Premium	Monthly Loan Payment	New Policies Only: Draft Initial Premium
		$	$	☐ Yes ☐ No
		$	$	☐ Yes ☐ No
		$	$	☐ Yes ☐ No

new policies only: Initial Modal Premium* **Draft will occur on the issue date of the policy.**

Policy Number / Product Applied for	Print Name of Insured	Initial Premium	Mode
		$	☐ Annual ☐ Semi-annual ☐ Quarterly
		$	☐ Annual ☐ Semi-annual ☐ Quarterly
		$	☐ Annual ☐ Semi-annual ☐ Quarterly

***EFT not available for Initial Premium on Annuity products.** Review the receipt to verify if the Proposed Insured qualifies to submit premium with the application. Note: Signing the Electronic Fund Transfer form does not mean that insurance is effective. Insurance is effective only if requirements of the Application for Insurance Receipt are satisfied.

The Company indicated above, hereby requested and authorized, subject to its approval, to draw checks, drafts or orders monthly, whether by electronic or paper means, to be charged against the (check one in each column): ☐ Checking ☐ Saving | ☐ Bank ☐ Credit Union

Bank Account Holder - print name and address as shown on Bank Records

Name of Bank and Branch Name, if any, and address where account is maintained

Transit/ABA Routing Number

Bank Account Number

- Refer to the check diagram at right to help determine your bank routing number and bank account number.**

****For Variable Life contracts and Annuity contracts, a copy of a Pre-printed Voided Check is required. In some other circumstances we will require a copy of a pre-printed, voided check or a letter from the bank indicating the ABA Routing Number, Account Number, and the Account Holder's Name for verification.**

IT IS UNDERSTOOD THAT: Either or both of the above arrangements may be terminated by the Policy Owner or by the Company upon written notice. If the Bank Account Holder ("Payor") is other than the Policy Owner, the Company will terminate either or both of the arrangements upon written request of such Payor. Should the Premiums cease to be paid by Electronic Payment, the Company will accept payment of quarterly, semiannual or annual premium payments at the Company's published rates in effect as of the date of the policy.

For Policies Earning Dividends: Dividends cannot be used to offset Electronic Premium Payments. If dividends are currently being used to reduce premiums, please submit a dividend change form (UN 3379 B).

As a convenience to me (Payor and undersigned), I hereby request and authorize the Company, to pay and charge to my account checks, drafts or orders, whether by electronic or paper means, drawn on my account by the Company to its own order. This authorization will remain in effect until revoked by me in writing, and until the Company actually receives such notice I agree that the Company shall be fully protected in honoring any such order.

I (Payor and undersigned) understand that premium payments are necessary to fund the policy. If my financial institution does not honor a withdrawal, I may be required to send the Company a replacement payment. If the Company does not receive a replacement payment within the time required, the policy may enter its grace period and then lapse. Once a policy lapses, it no longer offers life insurance coverage.

The bank shall be under no obligation to furnish me (Payor and undersigned) with any special advice or notice in writing or otherwise of the payment and charge of such checks, drafts, or orders to my account.

Declaration: By signing this form I certify that I am an authorized signature for the bank account listed above.

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Signature of Bank Account Holder | Date | Phone Number of Bank Account Holder