CNO Services, LLC
P. O. Box 1980
Carmel, IN 46032-1980
Premium Administration Fax: 1-800-757-6324

PREMIUM PAYMENT SERVICE PLAN (PPSP) AUTHORIZATION

- Complete this form in its entirety and include the signature of the bank account holder in Section D.
- Return completed form and evidence of your account information from your bank by mail or fax.

A POLICY AND ACCOUNT INFORMATION

Indicate which company you are electing to have premium payments withdrawn for:

☐ Bankers Life and Casualty Company

☐ Colonial Penn Life Insurance Company

1. Policy Number	Policyowner
2. Policy Number	Policyowner
3. Policy Number	Policyowner

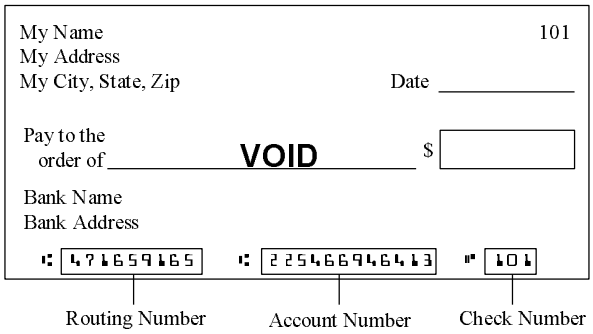
Name of Bank or Credit Union			
Address of Bank or Credit Union	City	State	Zip Code
Bank Routing Number	Bank Account Number		

You must provide evidence of your account from your bank. A voided check or pre-printed deposit slip is preferred or you may submit a letter from your bank verifying your routing and account number or a bank statement with the routing number handwritten on it. **Please contact your bank to make sure you have the appropriate ACH routing number.**

Account to be withdrawn from is a:

☐ Checking Account

☐ Savings Account



B REQUESTED WITHDRAWAL DATE

_____ (1st through the 28th)

This is the day you elect your payment to be withdrawn. If you do not choose a date, the date will default to the monthly premium due date. In the event the desired date is not available, the date closest to the selected/due date will be used. Payment draft dates that fall on weekends or holidays will draft the next business day. Monthly is the only mode offered for PPSP at this time.

C AMOUNT TO BE WITHDRAWN

$_____* *This field is for non-fixed premium policies. All fixed premium policies will draft the required premium amount due.

D AUTHORIZATION FOR ELECTRONIC BANK DRAFT

I hereby authorize CNO Services, LLC (hereinafter referred to as "Company") to make electronic transfers from my account, on behalf of the insurance companies listed above. I also authorize the financial institution indicated in this form to accept electronic transfers from Company. I hereby agree that if I do not pay any debit, for any reason whatsoever, the Company is hereby released from any and all liability of whatever nature, including with respect to any forfeiture of insurance arising out of the nonpayment of such debit. Items returned for non-sufficient funds and/or uncollected funds may be represented for payment. In order to revoke the effectiveness of this Authorization I must give ten business days advanced notice to the Company of my intentions to revoke the Authorization. Prior to the Company's receipt of notice of my intention to revoke the Authorization, and for a reasonable time after such receipt of notice, the Company retains the right to honor any debit to my account and that the Company will not incur any liability of any kind as a result of honoring any such debit.

Printed Name of Bank/Credit Union Account Holder	Signature of Bank/Credit Union Account Holder	Date