☐ Bankers Life and Casualty Company P.O. Box 1938 Carmel, IN 46082
☐ Colonial Penn Life Insurance Company P.O. Box 1938 Carmel, IN 46082

Premium Payment Service Plan – A convenient service for you

(1) Complete the below (2) Attach a voided check (3) Return to the Company or submit by fax to: Premium Administration – 1-800-757-6324

Authorization for electronic bank draft

As a convenience to me, I hereby request and authorize the company identified at the top of this form (hereinafter referred to as "Company") to make electronic transfers from my account. I also authorize and request the financial institution listed on this form to accept transfers from Company. I hereby agree that if any debit is not paid by me for any reason with or without cause or whether such nonpayment is intentional, inadvertent or otherwise, Company shall be under no liability whatsoever, even though such nonpayment may result in the forfeiture of insurance. Items returned for non-sufficient and/or uncollected funds may be represented for payment. Fees for returned items will be charged in accordance with Company's fee schedule. This authorization is to remain in full force and effect until revoked by me upon 30 days advance notice, and until you have actually received such notice, I agree that you shall be fully protected in honoring any such debit to my account until in such time and manner as to afford the Company a reasonable opportunity to act on it. Please note, contributions for Roth IRA must be that of the Owner or Spouse of the Owner of the contract, no other payor is permitted by law.

Date Bank or Credit Union account holder (Please Print) Signature of Bank or Credit Union account holder

Account Information

Withdrawal Day: _____ (This is the day you wish your payment to be withdrawn. Choose any day from the 1st through the 28th. If you do not choose a date, the date will default to the monthly premium due date.)

Frequency of Payment: ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually
(Some contracts do not permit all four modes of payment. If you elect a mode of payment that is not allowed by your contract, we will select the default payment mode for you.)

Amount* _____ *This field is for non fixed premium policies.

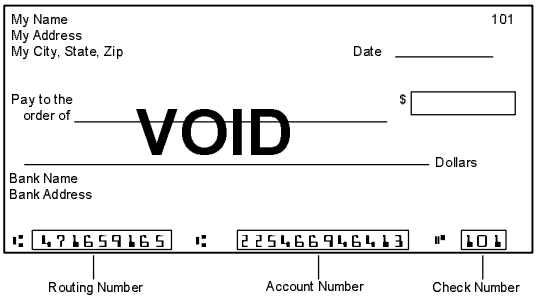
Policy _____ Insured's Name _____

Policy _____ Insured's Name _____

☐ PPSP Removal [ ] Month that draft is to be stopped (please allow 30 days notice)

☐ Checking Account (Attach a voided check: deposit slip is not acceptable) ☐ Savings Account *
*If savings is selected, please include a letter from the bank with your account and routing number and any special instructions for drafting from your account.

PLEASE ATTACH A PRE-PRINTED CHECK MARKED "VOID"
(Starter checks and deposit slips are not ACCEPTABLE)



Bank Transit/Routing No. Account No.

Name of bank or credit union

Address of bank or credit union

City State Zip

INDEMNIFICATION AGREEMENT

The company identified in this form (hereinafter referred to as "Company") is hereby authorized to make withdrawals from my account including checks, drafts or electronic fund transfers, payable to Company, pursuant to the accompanying or previously executed Agreement with the Company for the purchase of mutual fund shares and/or payment of premiums for insurance or annuity contract issued by Company. It is hereby agreed that: (1) The withdrawals reflected on my bank account will constitute receipts. (2) The plan may be revoked by company without prior notice if any account withdrawal is not paid upon presentation. The company shall be under no obligation to notify the undersigned as to non-payment of any account withdrawal. (3) The Plan is not a modification of any of the provisions of the Agreement between the Company and the undersigned. (4) This Plan may be discontinued by the Company upon thirty (30) days written notice to the owner indicated in the Agreement.

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