Lincoln Financial Group®

Electronic Funds Transfer (EFT) Authorization

Check One: ☐ **New EFT Account** ☐ **Existing EFT Account**

Policy/Certificate Number:	**Application Date:** *(New Business Only)*	**Insured(s) Name:** *(Please print.)*

Instructions for Premium Payment with Electronic Funds Transfer: *(Check the box that applies below.)*

New Business:

☐ Draft Initial Premium & All Subsequent Premiums

☐ Draft Balance of Initial Premium & All Subsequent Premiums

☐ Do Not Draft the Initial Premium or Any Balance Due

Inforce Policies/Certificates:

☐ Change Financial Institution or Account Number

☐ Indicate Planned Premium Payment Amount _____

☐ Draft Future Premiums Starting in the Month of : _____
(Confirmation of your Monthly Draft Date will be mailed to you.)

☐ Special Instructions _____

_____

New Business Important Note:

If you instruct the Company **to draft** the initial premium or the balance of the initial premium be aware that a) the Company will draft the total amount needed to cover all currently payable premiums, which may include more than one monthly premium. b) You will receive no further notice before the initial premium or balance draft. Confirmation of your monthly draft date will be mailed to you.

If you instruct the Company **not to draft** you will be expected to pay the initial premium, in an amount sufficient to cover currently payable premiums, when the policy/certificate is delivered to you.

Account Information

Please attach a VOID check if you plan to have the deduction taken from your checking account.

If you prefer to have the deduction taken from your savings account, please provide the following information:

_____ _____

Bank Routing & Transit Number Account Number

Authorization

I authorize the Company to collect premiums by electronic fund transfer, or to effect a charge by any other commercially accepted practice in connection with the policy(ies)/certificate(s) described above. The attached check (marked "VOID") shows the number of the account from which deductions are to be made. This Authorization will apply to any renewal, or change later made in the policy/certificate and in no way affects the terms of the policy(ies)/certificate(s). This Authorization is limited to the policy(ies)/certificate(s) described above.

If I change my financial institution, or my account number, or want to discontinue this agreement, I agree to give 30 days written notice to the Company. Notice to the financial institution without notice to the Company is not sufficient. The Company may terminate this agreement if any debit is not paid upon presentation. Any debit returned to the Company marked "insufficient funds or uncollected funds" will automatically be processed against the account a second time. The Company assumes no responsibility for bank charges or, in the case of registered security products, for investment losses on these debits.

_____ _____

Bank Depositor/Authorized Signature Date

_____ _____

Bank Depositor/Authorized Signature Date

Should you have any questions regarding this form, please contact your financial representative or the Company at the address or telephone number shown on your application.