



Aviva Life and Annuity Company  
 800/800-9882  
 P.O. Box 1555  
 Des Moines, Iowa 50306-1555

**Pre-Authorized Check  
 (PAC) Authorization  
 Form**

**MUST BE COMPLETED IN FULL** - (Please print or type all information except signatures. Please use black ink.)

Insured: \_\_\_\_\_  
 Owner: \_\_\_\_\_ Telephone No. of Owner: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
 Owner's Address: \_\_\_\_\_ Address Change Requested:

**CHECK APPROPRIATE BOX**

**TYPE OF REQUEST:**

FIRST REQUEST FOR PAC PLAN (A check with receipt of funds is needed for initial premium payments. First or initial premiums cannot be drawn automatically.)

ADD TO EXISTING PAC UNDER POLICY # \_\_\_\_\_

CHANGE OF BANKS, ACCOUNT NUMBER, OR PREMIUM PAYOR - allow 15 days for change processing.

**FOR USE ON NEW BUSINESS CASES ONLY:**

REQUESTED BILLED AMOUNT (Universal Life Only) \$ \_\_\_\_\_

PLEASE INDICATE DAY 1st - 28th \_\_\_\_\_

PAC WILL BE THE SAME AS POLICY DATE UNLESS OTHERWISE INDICATED.

Completion of this Authorization DOES NOT provide coverage under a Conditional Life Insurance Agreement.

**POLICIES TO BE INCLUDED IN THIS (PAC) PLAN**

Policy Number	Insured's Name	Premium/Loan Repay Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____

**AUTHORIZATION TO HONOR BANK WITHDRAWALS BY** (Must be completed):

PREMIUM PAYOR (Print Name as Shown on Financial Institution Records) \_\_\_\_\_

Financial Institution Name \_\_\_\_\_ hereinafter referred to as "You"

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Bank Routing No.          Bank Account No. \_\_\_\_\_

9 numbers required

Checking account  Savings account

**The Company may assess a \$25 fee if any withdrawal authorized herein is dishonored for any reason.**

I hereby request and authorize you to pay and charge to my account debit entries, including checks, drafts and other orders whether by electronic or paper means initiated on my account by the Company, to its own order. This authorization will remain in effect until revoked by me in writing in such time and in such manner as to afford you the Company a reasonable opportunity to act on it, and until you receive such notice, I agree that you shall be fully protected in honoring any such debit entry. In the event you comply with the above request and authorization, I agree that you may at any time cease your participation in and compliance with this request and authorization by giving thirty (30) days written notice to me and the Company.

I further agree that if such debit entry is dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. I understand this form is a bank authorization only and there will be no charge to my account until and unless a policy of insurance is issued by the Company.

X \_\_\_\_\_ X \_\_\_\_\_  
 (Signature of Premium Payor) (Additional signature if joint account)

X \_\_\_\_\_ Date \_\_\_\_\_  
 (Signature of Policyholder if other than Premium Payor)



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