The Penn Insurance and Annuity Company of New York
Administrative Office Mailing Address:
PO Box 390 Millville NJ 08332-0390
P: 1-855-436-0952

Premium Payment Authorization

This authorization shall apply to the following policy/application:
NAME OF INSURED _____ POLICY NUMBER _____

— PLEASE SELECT A PAYMENT METHOD AND COMPLETE SECTION A *OR* B BELOW —

❒ SECTION A: EFT-Electronic Funds Transfer — PAY BY CHECKING/STATEMENT SAVINGS

I request and authorize The Penn Insurance and Annuity Company of New York to pay premium from my account on the policy listed on this form. The presentation of withdrawal request forms shall constitute due notices of premiums due on the policy. This authorization may apply to any conversion, renewal, or change later made in said policy. The privilege of paying premiums under this plan may be revoked by the Company if any withdrawal request is not paid upon presentation. The payment of premiums under this plan may be discontinued by the Company or the undersigned upon ten (10) days written notice. I agree that if this authorization applies to an application for new life insurance, any coverage will become effective as defined in the application or the Temporary Insurance Agreement issued.

FINANCIAL INSTITUTION NAME AND ADDRESS

NAME _____

STREET
ADDRESS _____

CITY,
STATE & ZIP _____

A. TRANSIT ROUTING NUMBER
I: _____ I:

B ACCOUNT NUMBER:

_____

Type of account: ❒ Checking ❒ Statement Savings

If you wish to have the payment withdrawn on a date other than the policy due date please indicate below:
❒ 5th of the month ❒ 10th of the month ❒ other _____
Please contact financial institution for correct ACH information.

Date _____ Print Accountholder Name _____ Authorized Accountholder Signature _____

PLEASE ATTACH A VOIDED CHECK TO THIS FORM.

❒ SECTION B: PAY BY CREDIT CARD

I request and authorize The Penn Insurance and Annuity Company of New York to charge my credit card account identified below, for the payment to the Company for: an amount equal to the premium for the proposed policy and amount of life insurance applied for on the application to which this authorization is attached; and/or premiums due under the policy identified on this form. The Company agrees to accept this authorization as it would accept a check or draft, provided it is honored when presented for payment. I agree that if this authorization applies to an application for new life insurance, any coverage will become effective as defined in the application or the Temporary Insurance Agreement issued.

The privilege of paying premiums by credit card may be revoked by the Company if any charge to my account listed below is not honored upon presentation by the Company. The payment of premiums under this plan may be revoked by the account holder or by the Company upon ten (10) days written notice.

Credit Card Type: ❒ Visa ❒ Amex ❒ MasterCard ❒ Discover

If you wish to have the payment withdrawn on a date other than the policy due date please indicate below:
❒ 5th of the month ❒ 10th of the month ❒ other _____

Credit Card Account Number: _____ Security Code _____ Expiration Date: _____

Credit Card Billing Address: _____ _____ _____ _____
Address City State Zip Code

Date _____ Print Cardholder Name _____ Authorized Cardholder Signature _____