VantisLife Insurance Company
200 Day Hill Road
Windsor, CT 06095
1-866-826-8471 • www.VANTISLIFE.com

Premium Payment Authorization

This authorization shall apply to the following policy/application:

NAME OF INSURED _____ POLICY NUMBER _____

Payment Frequency: ❑Initial Premium* ❑Recurring Premiums ❑Both Initial and Recurring Premiums

*Initial premium will be charged or drafted upon approval or receipt of TIA - whichever applies.

PAY BY CREDIT CARD

I request and authorize VantisLife Insurance Company 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 ❑Other: _____

Credit Card Account Number: _____ Expiration Date: _____

Cardholder Name: _____ Date: _____ Authorized Cardholder Signature: _____
Please Print

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

PAY BY EFT/Electronic Funds Transfer

1. I authorize you to pay premium from my account on the policy listed on this form.
2. The presentation of withdrawal request forms shall constitute due notices of premiums due on the policy.
3. This authorization may apply to any conversion, renewal, or change later made in said policy.
4. The privilege of paying premiums under this plan may be revoked by the Company if any withdrawal request is not paid upon presentation.
5. The payment of premiums under this plan may be discontinued by the Company or the undersigned upon ten (10) days written notice.

_____ _____ _____
Date Print Name Customer Signature

FINANCIAL INSTITUTION NAME AND ADDRESS

NAME _____

STREET ADDRESS _____

CITY, STATE & ZIP _____

A. TRANSIT ROUTING NUMBER:
|: |:

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.

❑**5 th of month** ❑**10 th of month** ❑**other** _____
please specify

Please contact financial institution for correct ACH information.

PLEASE ATTACH A VOIDED CHECK TO THIS FORM.