



**REQUEST FOR CENTRAL RESERVE LIFE INSURANCE COMPANY
 ELECTRONIC FUNDS TRANSFER**

Name of Bank Depositor

 (Print Name as Shown on Bank Records)

TO: CENTRAL RESERVE LIFE INSURANCE COMPANY (CRL)

I/we hereby request and authorize CRL to initiate debit entries on my/our checking account indicated below:

 (Name of Bank and Branch Name, if any)

 (Transit Number)

 (Address of Bank or Branch where account is maintained)

 (Account Number)

This authorization is limited to the payment to CRL of the monthly premiums hereafter becoming due on Account Number _____ issued on the life of _____ and is subject to the following conditions:

1. The electronic funds transfer(s) shall constitute notice of premiums due and upon being charged to my account by the bank shall be my receipt for payment of the designated premium(s).
2. Premiums must be paid within the time stipulated in the policy(ies) for payment, and if any debit is not honored by the bank upon presentation and default in payment occurs, the policy(ies) shall become null and void except as otherwise provided therein.
3. I will indemnify and hold CRL harmless from any liability of any kind, sort or character by virtue of the negotiation, presentation or payment of any debit drawn by CRL, in accordance with this request and authorization, in payment of any premium(s) on the policy(ies) designated.
4. The privilege of paying premiums under an electronic funds transfer may be revoked by CRL if any debit is not paid upon presentation, and the Plan may be discontinued by CRL, the premium payer or the bank at any time upon written notice.
5. This authorization is to remain in full force and effect until CRL has received written notification from the Insured of its termination. Notice must be provided at least ten business days prior to next scheduled debit date.

NOTE: All written debit authorization(s) must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

 Date Signature of Bank Depositor -- as shown on Bank Records for the account to which this Authorization is applicable.

The authorization is applicable to the following:

ACCOUNT NO(S).

NAME OF INSURED OR APPLICANT

_____ / _____ / _____	_____
_____ / _____ / _____	_____
_____ / _____ / _____	_____
_____ / _____ / _____	_____
_____ / _____ / _____	_____
_____ / _____ / _____	_____

Please select the desired draft date from the choices below:

Draft Date Selected: 1st 10th 15th 25th

If you choose to change your draft date in the future, 30 days advanced notice is required.

PLEASE ATTACH VOIDED CHECK