Fidelity Life Association
P.O. Box 5030
Des Plaines, IL 60017
Tel 800.369.3990
Fax 866.947.8738

Policy Number

CUSTOMER SERVICE -Premium Payment Options

Policyowner Name (please print) _____ Daytime Phone # _____

Insured's Name (please print) _____ Insured's Date of Birth _____ Daytime Phone # _____

Payor's Name (please print) _____ Daytime Phone # _____

Payor's Address _____ City _____ State _____ Zip _____

Secondary Address (if needed to receive duplicate copies of billing correspondence)

Secondary Addressee Name (please print) _____ Daytime Phone # _____

Secondary Addressee Address _____ City _____ State _____ Zip _____

SECTION 1: AUTOMATIC WITHDRAWAL (Void Check Required)

☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium will be deducted on the same day of the month as the policy date. If you prefer a different withdrawal date, please indicate in the space provided. (Choose from days 1-28 only): _____ The amount of the debit is shown on the premium schedule page of your policy.

Name of Financial Institution _____

ABA Routing Number ___ ___ ___ ___ ___ ___ ___ ___ ___ City _____ State _____

Account Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ☐ Checking ☐ Savings

(must include dashes & spaces as they appear in your account number)

Attach payment and/or void check (Please staple your check to the left margin)

SECTION 2: CREDIT CARD

NOTE: Fidelity Life recommends that the payor call Customer Service at (800) 369-3990 to provide the credit card information.

Automatic payment by credit card: ☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

Name as it appears on card _____

(Please print)

Card Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Expiration Date ___ ___ / ___ ___

SECTION 3: DIRECT BILL

☐ Quarterly ☐ Semi-annually ☐ Annually **Attach payment (**Please staple your check to the left margin**)**

SECTION 4: AUTHORIZATION

I authorize the company to draw checks, drafts or electronic debits against my account, or charge my credit card for the necessary premium to continue my coverage. This authorization shall remain in effect until revoked in writing by me or the Company. I understand that if I have chosen Option 2 above, the Company will charge my card for subsequent premiums.

Payor's Signature _____ Date _____ City and State _____