



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: Payor can provide credit card information by logging in to the customer portal on FidelityLife.com or calling Customer Service at (800) 369-3990.**

#### 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 \_\_\_\_\_