

Authorization for Direct Deposit

INSURER

OM Financial Life Insurance Company

Name _____ OM Financial Life Contract ID # _____ Social Security # _____

Residential Address _____ City _____ State _____ Zip Code _____

Phone Number: Home _____ Work _____
(_____) (_____)

Please check one circle only: Authorization Cancellation Change Correction

Financial Institution Name _____
Name(s) in which account is held _____
Your Account Number _____
Bank Routing (ABA) Number _____
Deposit to: <input type="radio"/> Checking (attach voided check) <input type="radio"/> Savings
Bank Telephone Number (_____) _____

I (We) hereby authorize OM FINANCIAL LIFE INSURANCE COMPANY ("Company") to deposit my net benefit payment with the financial institution named above ("Bank") and the Bank to credit the same to my account as described above.

This authorization is to remain in force until the Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the Company and/or the Bank a reasonable opportunity to act on it.

In the event that the Company notifies the Bank that funds to which I (we) am not entitled have been deposited to my (our) account inadvertently, I (we) hereby authorize and direct the Bank to return said funds to the Company as soon as possible.

This payment option does not in any manner amend or alter the terms and provisions of any policy, contract, or agreement with the Company.

This authorization is governed by Maryland law, including the Maryland Uniform Commercial Code.

Signature _____ Date _____

Signature (if jointly owned, both parties must sign) _____ Date _____

Before mailing, please remember to attach a voided check or deposit slip from your account.