## **Principal Life Insurance Company**

PO BOX 14455, Des Moines, IA 50306 www.principal.com

## Electronic Fund Transfers Individual Disability Income

Call: 800.247.9988
Fax: 866.825.4779
Email: diservice@principal.com



Select Payment Mode (Please choose one): Semi-Annual Monthly (ONLY available with EFT) Quarterly Annual Policy/Contract Number: \_ Insured Name: \_\_ COMPLETE THIS SECTION FOR: NEW ISSUE POLICIES ONLY NOTE: We are unable to draw funds if this form is incomplete or unsigned. Any Conditional Receipt coverage will be void. Please refer to the Conditional Receipt (AA1751/AA2250 as applicable) for terms and conditions. Select all that apply (you must choose at least one): □ Draft initial payment upon receipt of application (Enter amount of draft: \$\_\_\_\_\_\_ \_): I authorize an immediate draft for the initial payment as indicated by the selected mode above. Any applicable shortage in payment due will be drawn when all delivery requirements are received. Draft payment at delivery: I authorize a draft for the initial payment (including any shortage due) as indicated by the selected mode above when my policy is delivered. Recurring Automatic EFT Payment: I authorize payments to be drawn on a recurring basis as indicated by the selected mode above. Billing notices will not be mailed for monthly mode. IF INITIAL AND RECURRING PAYMENTS ARE TO BE DRAFTED FROM DIFFERENT ACCOUNTS. COMPLETE A SEPARATE FORM FOR EACH. **Bank Information:** Special Draw Date (1st - 28th): Enter requested draft date\_ Please note: Depending upon your financial institution, it may take up to three to five business days for the transaction to show in your account. ☐ Checking\* Account ☐ Savings\* Account \*Deposit slips should not be used to verify banking information as routing numbers will vary. BANK NAME ROUTING NUMBER (9 DIGITS) ACCOUNT NUMBER (INCLUDE ALL PRECEDING ZEROS ON YOUR ACCOUNT NUMBER) ACCOUNT HOLDER'S PHONE NUMBER ACCOUNT HOLDER'S NAME JOINT ACCOUNT HOLDER'S NAME ACCOUNT HOLDER'S EMAIL ADDRESS I authorize Principal Life Insurance Company (hereafter referred to as "Company") to debit my account as indicated above. **Authorization Agreement:** I authorize the financial institution named above to honor withdrawals and/or electronic fund transfers by the Company listed above. I understand if any withdrawals are dishonored, whether with or without cause, that the company shall be under no liability. This authorization will remain in effect until cancelled either by myself, the Company, or the financial institution named above. If this form is not dated, it will be effective the date it is received in our Home Office. Signature of Account Holder Print Name of Account Holder Date (Include title if Corporate owner or "trustee" if Trust owned) Signature of Joint Account Holder Print Name of Joint Account Holder Date

(Include title if Corporate owner or "trustee" if Trust owned)