



American Republic Insurance Company
 P.O. Box 9371, Des Moines, Iowa 50306

**Automatic Payment Plan ...
 The Automatic Way To Pay**

Name _____

Billing number _____

The following coverage is to be billed through Automatic Payment Plan: *(Please check all that apply)*

All coverage currently in force

Only the coverage(s) marked below

Medicare Supplement

Major Medical

Express Life

Tailored Term

Nursing Home

Life Insurance

Cancer Care

Critical Illness

Other *(Please specify)* _____

I would like payments withdrawn from my checking savings account each month.

Authorization to Bank or Other Financial Institution

Account number: _____

Your name: _____
 (Please print your name as shown on your account)

To: _____
 (Bank or Financial Institution name, also branch if any)

 (Street Address) (Town) (State) (Zip)

I authorize you to pay and to charge to my account the amount of any check, instrument, or any other funds transfer made by and payable to American Republic Insurance Company for insurance payments. I authorize American Republic Insurance Company to contact my Bank or Financial Institution in my behalf for the sole purpose of obtaining information necessary to administer my preauthorized withdrawals in conjunction with my insurance policy/certificate. This authorization is to remain in effect until revoked by me in writing. Until you receive and have had reasonable time to act on such notice you shall be fully protected in accepting any preauthorized withdrawals against my account.

_____ X _____
 Date Your signature as shown on your account

Please attach a voided check from your account.