

- Transamerica Financial Life Insurance Company**
440 Mamaroneck Avenue, Harrison, NY 10528
- Transamerica Life Insurance Company**
- Transamerica Premier Life Insurance Company**
- Stonebridge Life Insurance Company**
Administrative Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

**SOCIAL SECURITY BENEFIT
BILLING AUTHORIZATION FORM**

POLICY NUMBER _____

SOCIAL SECURITY BENEFIT PAYMENT PAID ON:

Box A - Required

Please select only one box to indicate the DEPOSIT/WITHDRAWAL options:

- | | |
|---|---|
| <input type="checkbox"/> Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A)
<input type="checkbox"/> Benefits paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SSI payments (Option B) | <input type="checkbox"/> Benefit paid on Second Wednesday (Option C)
<input type="checkbox"/> Benefit paid on Third Wednesday (Option D)
<input type="checkbox"/> Benefit paid on Fourth Wednesday (Option E) |
|---|---|

Initial Draft Month _____ (Cannot exceed one benefit payment cycle past application date)

INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)

Box B - Bank Withdrawal Account

Insured Name: _____ Birthdate of Insured: _____

Payor Name if different than Insured: _____ Birthdate of Payor: _____

Financial Institution Name, Office or Branch _____

Financial Institution Address City, State, Zip _____

Check One: Checking Savings \$ _____

List All Authorized Account Holders _____

Premium amount

Transit Routing Number _____ Account Number _____

Account Holder Signature _____

Box C - Direct Express MasterCard

Insured Name: _____ Birthdate of Insured: _____

Payor Name if different than Insured: _____ Birthdate of Payor: _____

5332 48 _____
Direct Express MasterCard Account Number

\$ _____

Cardholder Signature _____ Date _____

Premium amount

Card Expiration Date _____ Mo/Yr _____

Cardholder Name (Please Print) _____

I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/or such other payments as I may authorize the Companies to make. I request the charges or withdrawals be on or before the day(s) when payments fall due. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal or change later made to the policy(ies). I understand that if a charge or withdrawal is not honored for payment, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.

As a convenience to me, I hereby request MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.

This authorization shall take effect when recorded and processed by the Companies and financial institution and will remain in effect until I notify the Companies or the financial institution in writing to terminate and the Companies or financial institution have a reasonable time to act on the termination request. I hereby terminate any prior authorization of the Companies to initiate charges to my card or withdrawals from this account for the above policy(ies) effective the date on which the initial charge or withdrawal is made under this authorization. I also understand and agree that if a charge or withdrawal is not honored by the financial institution for any reason, the Companies may cease attempting to make charges or withdrawals through the use of this authorization.

Signature of Authorized Account Holder _____

Date _____