



**NATIONAL TEACHERS ASSOCIATES  
LIFE INSURANCE COMPANY**

P.O. Box 2429, Addison, TX 75001-2429

Customer Service: (888) 671-6771 • Fax: (972) 532-2197

**Policy Number (if known)**

*Use our convenient Bank Draft Authorization or Credit Card Billing for automatic payment of your insurance premium from your Bank Account or your Credit Card.*

**BANK DRAFT AUTHORIZATION**

I request and authorize National Teachers Associates Life Insurance Company to make withdrawals against the bank account specified on the attached specimen check, or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them for the purpose of collecting premiums under the policy. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect to receive such notice only when such entry differs from the previous entry by more than \$200. This request and authorization shall remain in force until terminated by me in writing at least 30 days prior to the effective date of the termination.

\_\_\_\_\_  
Printed Name

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature exactly as it appears on bank records Date Signed

Requested first draft date (1-28 only)

**PLEASE ATTACH A SPECIMEN CHECK MARKED "VOID"**

**CREDIT CARD PAYMENT AUTHORIZATION FORM**

I authorize you to charge the credit card listed below for premiums due. I authorize increases or decreases to the amount noted below to correspond with the policy premium as issued or as modified in accordance with the terms of the policy. I may discontinue any recurring charges by giving you 15 days advance written notice. All adjustments or disputes will be handled by your Home Office and not by my credit card company.

Exact name as on credit card: \_\_\_\_\_  
Print Name Signature

Credit Card Type:  Discover  VISA  MasterCard

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ \*Code: \_\_\_\_\_

\* As part of our commitment to your security and privacy, we require some additional information in order to process your request. Please enter the three or four digit code which can be found after the account number on the back of your credit card.

Credit Card billing address (if different from application) \_\_\_\_\_

Frequency: Check all blocks applicable. (Note: If paying both the initial premium and recurring premiums by credit card, check both the first and second block.)

- Bill for the Initial Premium Deposit in connection with insurance applied for.
- This is a Preauthorized Order to bill for the Recurring Premiums on the premium's due date.
  - Monthly  Quarterly  Semi-Annual  Annual

Amount: \$ \_\_\_\_\_

**HOME OFFICE USE ONLY**

Payment Authorization applicable to the following policy numbers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Amount Charged \$ \_\_\_\_\_



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