

SERFF Tracking Number: HULI-126571815 State: Arkansas  
 Filing Company: Heritage Union Life Insurance Company State Tracking Number: 45407  
 Company Tracking Number: HU-TL-RDR203-205  
 TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium  
 Product Name: Guaranteed Minimum Rider  
 Project Name/Number: Guaranteed Minimum Riders/

## Filing at a Glance

Company: Heritage Union Life Insurance Company

Product Name: Guaranteed Minimum Rider SERFF Tr Num: HULI-126571815 State: Arkansas  
 TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- State Tr Num: 45407  
 Closed

Sub-TOI: L04I.313 Decreasing - Single Life - Co Tr Num: HU-TL-RDR203-205 State Status: Approved-Closed  
 Fixed/Indeterminate Premium

Filing Type: Form Reviewer(s): Linda Bird  
 Authors: Kim Hiar, Teresa Lockette Disposition Date: 04/14/2010  
 Date Submitted: 04/13/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:  
 State Filing Description:

## General Information

Project Name: Guaranteed Minimum Riders  
 Project Number:  
 Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed  
 Date Approved in Domicile:  
 Domicile Status Comments: Exempt from filing in Arizona.

Explanation for Combination/Other:  
 Submission Type: New Submission  
 Overall Rate Impact:  
 Filing Status Changed: 04/14/2010

Market Type: Individual  
 Group Market Size:  
 Group Market Type:  
 Explanation for Other Group Market Type:  
 State Status Changed: 04/14/2010  
 Created By: Teresa Lockette  
 Corresponding Filing Tracking Number:

Deemer Date:  
 Submitted By: Kim Hiar  
 Filing Description:

These riders will be attached to a base policy which provides, upon death, periodic monthly benefits until the insured would have reached a particular age (which can vary by policy form.) These riders provide a guarantee that a minimum number of benefit payments are made, regardless of the insured's date of death while the base policy and rider are in force. These riders are being filed for general use with any previously approved policy forms, as well as any future policy forms we may develop. The riders are nonparticipating.

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These riders will be issued with the following policy forms and the corresponding policy specifications pages. These forms were previously approved as follows:

Form Number	Description	SERFF Tracking #	Approval Date
HU-TL-APP320A	Term Life Application	HULI-126094738	4/2/2009
AL-TL-POL300B.AR	Decreasing Term Life to Age 65	HULI-125571367	4/7/2008
HU-TL-POL100B.AR	Decreasing Term Life to Age 65	HULI-126533692	3/18/2010
HU-TL-POL500B-AR	Decreasing Term Life to Age 75	HULI-126550959	4/9/2010

This product will be marketed through both the agent channel and the direct response channel, including mail, radio and television. This product will not be marketed with an illustration.

We reserve the right to change layout and font type in the future. Should you have any questions or need additional information, please contact me at 804-201-4733 or email me at [teresa.lockette@heritageunion.com](mailto:teresa.lockette@heritageunion.com).

## Company and Contact

### Filing Contact Information

Kim Hiar, Compliance Manager	<a href="mailto:kimberly.hiar@heritageunion.com">kimberly.hiar@heritageunion.com</a>
1805 Monument Avenue	804-212-2818 [Phone]
Suite 201	804-213-0051 [FAX]
Richmond, VA 23220	

### Filing Company Information

Heritage Union Life Insurance Company	CoCode: 62421	State of Domicile: Arizona
1805 Monument Avenue	Group Code: 181	Company Type: Life & Health Insurer
Suite 201	Group Name:	State ID Number: 2058
Richmond, VA 23220	FEIN Number: 41-0880965	
(804) 212-2818 ext. [Phone]		

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No

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Fee Explanation: 2 forms @ \$50.00/form  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Heritage Union Life Insurance Company	\$100.00	04/13/2010	35591898

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	04/14/2010	04/14/2010

*SERFF Tracking Number:* HULI-126571815      *State:* Arkansas  
*Filing Company:* Heritage Union Life Insurance Company      *State Tracking Number:* 45407  
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Fixed/Indeterminate Premium  
  
*Product Name:* Guaranteed Minimum Rider  
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## **Disposition**

Disposition Date: 04/14/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	GMP Rider- 5 year		Yes
Form	GMP Rider- 3 year		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	HU-TL-RDR205	Policy/Cont GMP Rider- 5 year ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		41.900	HU-TL-RDR205 Guar Min Rider 5-year-Final.pdf
	HU-TL-RDR203	Policy/Cont GMP Rider- 3 year ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		42.700	HU-TL-RDR203 Guar Min Rider 3-year-Final.pdf



# HERITAGE UNION LIFE INSURANCE COMPANY

Executive Offices: 1805 Monument Avenue, Suite 201  
Richmond, Virginia 23220

## GUARANTEED MINIMUM PAYOUT RIDER

**Rider Effective Date: [01/01/2010]**  
**Insured's Rider Issue Age: [35]**

**Rider Expiration Date: [01/01/2040]**  
**Rider Modal Premium: \$[0.90]**

This Rider, attached to and made a part of the Policy, modifies the Benefit Amount section of the Policy Schedule. Notwithstanding any language in the policy to the contrary, we will make at least 60 monthly benefit payments, regardless of when death occurs while the policy and this rider are in force.

This Rider is a part of the Policy. All terms and conditions of the Policy apply to this Rider unless otherwise noted in this Rider.

This Rider is issued in consideration of application for this Rider and the payment of the first premium for this Rider.

Premiums for this Rider will be added to the Policy Premium shown on the Policy Schedule. If this Rider is terminated, the total premium for the Policy will be reduced by the amount of premium for this Rider.

We agree to pay the Rider Benefit Amount to Your Beneficiary in accordance with the Policy Proceeds section of the Policy.

### DEFINITIONS

**Rider Benefit** – is the benefit shown on the Policy Schedule or in a Supplemental Rider Specification Page.

**Rider Effective Date** – is the date that coverage under this Rider becomes effective. The Rider Effective Date is the Policy Date unless a different Rider Effective Date is shown in a Supplemental Rider Specification Page attached to this Policy. Rider years are measured from the Rider Effective Date.

**Rider Expiration Date** – is the date on which the insurance coverage under this Rider ends. The Rider Expiration Date is shown on the Supplemental Rider Specification Page.

**Policy** – in this Rider, Policy means the Policy to which You have requested that this Rider be attached.

**Premiums** – Premiums for this Rider are shown in the Supplemental Rider Schedule.

### GENERAL PROVISIONS

**Incontestability** – This Rider is subject to the Incontestability provisions of the Policy. However, the contestable period for this Rider shall be measured from the Rider Effective Date.

**Suicide** – If the Insured commits suicide, while sane or insane, within two years from the Rider Effective Date, except in Colorado and North Dakota, such period shall be one year, Our liability will be limited to an amount equal to the total premiums paid for this Rider.

Termination – This Rider will terminate on the earliest of the following dates:

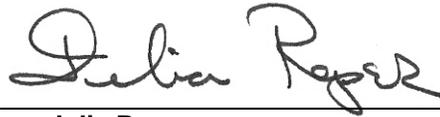
1. The Expiration Date of this Rider;
2. The Expiration Date of the Policy;
3. The date the Policy terminates as set out in the Grace Period provision of the Policy;
4. The date the Policy is terminated;
5. The date We receive Your written request to terminate this Rider; or
6. The date of the Insured's death.

Issued and signed for Heritage Union Life Insurance Company,  
an Arizona domestic life insurance company



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**Philip Walker**  
Chairman and CEO



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**Julia Roper**  
President



## Heritage Union Life Insurance Company

Executive Offices: 1805 Monument Avenue, Suite 201  
Richmond, Virginia 23220

### **GUARANTEED MINIMUM PAYOUT RIDER**

**Rider Effective Date: [01/01/2010]**  
**Insured's Rider Issue Age: [35]**

**Rider Expiration Date: [01/01/2040]**  
**Rider Modal Premium: \$[0.90]**

This Rider, attached to and made a part of the Policy, modifies the Benefit Amount section of the Policy Schedule. Notwithstanding any language in the policy to the contrary, We will make at least 36 monthly benefit payments, regardless of when death occurs while the policy and this rider are in force.

This Rider is a part of the Policy. All terms and conditions of the Policy apply to this Rider unless otherwise noted in this Rider.

This Rider is issued in consideration of application for this Rider and the payment of the first premium for this Rider.

Premiums for this Rider will be added to the Policy Premium shown on the Policy Schedule. If this Rider is terminated, the total premium for the Policy will be reduced by the amount of premium for this Rider.

We agree to pay the Rider Benefit Amount to Your Beneficiary in accordance with the Policy Proceeds section of the Policy.

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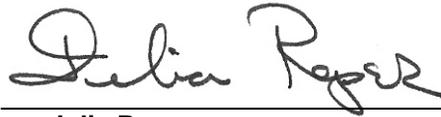
1. The Expiration Date of this Rider;
2. The Expiration Date of the Policy;
3. The date the Policy terminates as set out in the Grace Period provision of the Policy;
4. The date the Policy is terminated;
5. The date We receive Your written request to terminate this Rider; or
6. The date of the Insured's death.

Issued and signed for Heritage Union Life Insurance Company,  
an Arizona domestic life insurance company



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**Philip Walker**  
Chairman and CEO



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**Julia Roper**  
President

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## Supporting Document Schedules

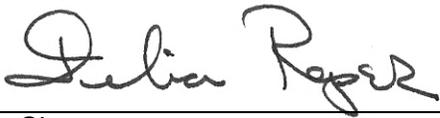
	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachment:</b> Certification of Compliance.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Application		
<b>Comments:</b> The attached application will be used with the riders being filed. This application has been approved as follows:		
HU-TL-APP320A- Approval Date 04/02/2009 SERFF Tracking# HULI-126094738		
<b>Attachment:</b> HU-TL-APP320A 3-27-09.pdf		

CERTIFICATION OF COMPLIANCE

I certify that in preparation of this filing all statutes, regulations, rules and bulletins have been reviewed, including Rule 19 and Rule 49.

I also certify that all forms contained in this filing comply with the minimum flesch score of 40 as required in Arkansas ACA 23-80-206.



\_\_\_\_\_  
Signature

April 6, 2010

\_\_\_\_\_  
Date

Julie Roper

\_\_\_\_\_  
Name

President

\_\_\_\_\_  
Title

### ABOUT PROPOSED INSURED (Please answer each question completely)

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone \_\_\_\_\_

Best time to call:  Morning  Afternoon  Early Evening

Alternate Phone \_\_\_\_\_

Best time to call:  Morning  Afternoon  Early Evening

Email Address \_\_\_\_\_

Current Occupation \_\_\_\_\_

Annual Salary \$ \_\_\_\_\_  Male  Female

Product \_\_\_\_\_

Monthly Benefit Amount \$ \_\_\_\_\_

[Payout Period] \_\_\_\_\_

Rider(s)/Amount \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Birthplace \_\_\_\_\_  
month day year state or country

Height \_\_\_\_ feet \_\_\_\_\_ inches Weight \_\_\_\_\_ pounds

SS# \_\_\_\_\_

Driver's License # \_\_\_\_\_ State Issued \_\_\_\_\_

Are you a citizen of the United States?  Yes  No

If no, do you have a permanent Visa (green card)?  Yes  No

#### POLICY OWNER'S INFORMATION (If different from Proposed Insured)

Policy Owner's Name: \_\_\_\_\_

Policy Owner's Street: \_\_\_\_\_

Policy Owner's City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy Owner's SS# or Tax Payer ID#: \_\_\_\_\_

#### BENEFICIARY INFORMATION

Name, Relationship and Designated %:

### APPLICANT HISTORY (Check YES or NO for each question. If yes, provide details.)

1. a. Do you have other life insurance applications pending with any other company? .....  Yes  No
  - b. By applying for the proposed policy do you intend to replace, discontinue or change an existing policy or contract? .....  Yes  No
- If yes, provide details as follows. Attach a separate sheet if more space is needed (\*Indicate Type of Coverage: I=Individual; B=Business; or G=Group)

INSURED NAME	INSURANCE COMPANY	POLICY NO.	AMOUNT	*TYPE	PENDING	ISSUE DATE
					<input type="checkbox"/>	
					<input type="checkbox"/>	

2. Have you, in the past 2 years, used Tobacco or Nicotine products in any form? .....  Yes  No
3. Within the past 3 years, have you been refused life insurance or been issued a policy on a modified or rated basis? .....  Yes  No
4. Have you, in the past 3 years, participated in or do you plan to participate in any in any of the following activities: aeronautics, including hang gliding, sky diving, parachuting, or ballooning; racing, including car, motorcycle, or boat; scuba/skin diving; hiking, including mountain/trail climbing or rock climbing; or any similar hazardous activities? .....  Yes  No
5. Have you, in the past 3 years, piloted an aircraft, or do you have any intention of flying in the future other than as a passenger on a scheduled airline? .....  Yes  No
6. Do you contemplate residence or travel, including military deployment, outside the US during the next 2 years? .....  Yes  No
7. Have you, in the past 3 years, had your driver's license suspended, revoked, cancelled, or withdrawn, had 3 or more moving violations, or in the past 5 years pleaded guilty or no contest to or been convicted of driving under the influence (DUI/DWI) or reckless driving? .....  Yes  No
8. Have you, in the past 10 years, pled guilty or no contest to or been convicted of a felony offense, or been on probation or parole for a felony offense, or are felony charges currently outstanding against you? .....  Yes  No
9. Have you, in the past 10 years, used illegal drugs, or consulted a physician or other healthcare provider or been treated, hospitalized, or taken medication for abuse of alcohol or drugs (including prescription drugs)? .....  Yes  No

- 10.** Have you, in the past 10 years, had, consulted a physician or other healthcare provider, or been treated, hospitalized or taken medication for: any diseases or disorders of the heart including rheumatic fever, circulatory system, diabetes/endocrine/thyroid, blood, kidneys, liver, digestive system, lungs including allergies, sleep apnea, respiratory disorder, emphysema, or chronic asthma; any mental or nervous disorders, including depression or anxiety; muscular, spinal, joint, or bone disorders or injuries; including concussions; high blood pressure; high cholesterol; cancer; stroke; epilepsy/seizures, including dizziness or fainting; arthritis; congenital defects or physical impairments; or sexually transmitted diseases? .....  Yes  No
- 11.** Have you ever tested positive for, or been treated for, been hospitalized for, or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) antibodies or antigens or AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or any immune deficiency disorder? .....  Yes  No
- 12.** Have you, in the past 12 months, been confined to a hospital or medical facility of any kind for more than 24 hours? .....  Yes  No
- 13.** In the past 12 months have you scheduled or been advised to have surgery, a diagnostic test, an x-ray, electrocardiogram, blood test or any other laboratory tests, or evaluation of any kind? .....  Yes  No
- 14.** In the last 5 years, have you:
- a. Been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions and activities? .....  Yes  No
- b. Taken prescription drugs for longer than 15 days? .....  Yes  No
- 15.** Have any of your immediate family members (parents or siblings) been diagnosed or died from coronary artery disease, cancer or diabetes prior to age 60? .....  Yes  No

## PAYMENT OPTIONS (Choose One):

Payer:  Proposed Insured  Policy Owner (if different than proposed insured) Choose a billing frequency:  Monthly  Quarterly  Semi-annually  Annually

**Agreement/Authorization to Obtain and Disclose Information:** I have read all the questions and answers on this application. All responses are true and complete to the best of my knowledge and belief. A copy of this application will be attached to and made a part of the insurance contract. Any insurance issued as a result of this application will not take effect until the full first premium is paid and a policy is delivered to and accepted by the Proposed Insured during his/her lifetime and while such person is in the state of health described in all parts of this application. I acknowledge receiving the "NOTIFICATION" regarding MIB, Inc. and Fair Credit Reporting Act in the enclosed materials. For use in determining insurability, research, or any other purpose not prohibited by law, I authorize any licensed physician, medical practitioner, MIB, Inc., any pharmacy related service organization, or consumer reporting agency that has any records or knowledge of the Proposed Insured's medical history to give any such information to Heritage Union Life Insurance Company, its representatives, or reinsurers. This authorization is valid for 24 months from the date signed. A photocopy or facsimile of this authorization will be as valid as the original. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the Company except as authorized by me or as required by law. I understand that I or any authorized representative will receive a copy of this authorization upon request. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. All applications are subject to underwriting approval which may include, but is not limited to, income verification, medical examination, laboratory testing, MVR, prescription records, and telephone interview.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **CO Residents:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the

purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **DC Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include, imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant. **KY Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **MD Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **OH Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud. **OK Residents:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **OR Residents:** Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. **TN Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed at City \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Proposed Insured (Required – Do not print) \_\_\_\_\_  
 Policy Owner Signature (If Different than Proposed Insured) \_\_\_\_\_

## FOR AGENT USE

To the best of my knowledge, replacement of an existing life insurance policy or annuity contract  is  is not involved in this transaction.

Agent Signature \_\_\_\_\_  
 Agent Name (Printed) \_\_\_\_\_  
 Agent Number \_\_\_\_\_  
 Signed at City \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_

## **ADDITIONAL APPLICATION INFORMATION BELOW**

# Authorization For Payment by Electronic Funds Transfer or Credit Card

## POLICY OWNER INFORMATION

First Name \_\_\_\_\_ MI \_\_\_\_\_

Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS# \_\_\_\_\_

## PAYMENT OPTIONS (Choose One):

Choose a billing frequency:  Monthly  Quarterly  Semi-annually  Annually

Automatically Deduct Premium from:  Savings  Checking

Bank Name \_\_\_\_\_

Account Holder (Payer) Name (Please Print) \_\_\_\_\_

Account Number: \_\_\_\_\_

Routing Transit No.: \_\_\_\_\_

*Example of routing/transit and account numbers found on the bottom of your personal check*



**OR** Charge Premium to:  Visa  MasterCard  Discover  American Express

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

## BILLING ADDRESS

Same as Mailing Address Above

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I authorize Heritage Union Life Insurance Company to deduct from my account indicated above and I authorize the above named financial institution to honor the withdrawal. I understand that this authorization is to remain in effect until cancelled by me, Heritage Union Life Insurance Company or the Financial Institution named above. To terminate or change this service, I must notify Heritage Union Life Insurance Company at least 30 business days prior to the day that my premium is due to prevent electronic payment drafting.

Signature (Required – Do not print) \_\_\_\_\_