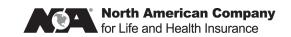
Electronic Funds Transfer for Withdrawals



I. This authorization gives North American Company for Life and Health Insurance® and your Financial Institution named below the <u>authority to deposit your withdrawals</u> directly to your designated account. You should generally expect to have your funds available in your account within three (3) business days of the date of processing by North American. North American is not responsible for any direct or indirect loss of interest, expenses, penalties, fees, costs, or other monetary consequences related to or arising from the electronic funds transfer (EFT) process.

II. Owner, Joint Owner and/or Trust Information
Contract Number (Please note that EFT is not available on contracts that have a contract number beginning with 15, 16, and 25.)
☐ I have multiple contracts with North American. Please use this bank information to update all contracts.
Owner First Name MI Last Name Phone
Owner Email Address (optional)
Joint Owner First Name MI Last Name Phone
Trust Name Phone
This authorization will remain in effect until North American and your Financial Institution have each received written
notification of its termination in such time and in such manner as to afford them a reasonable opportunity to act on the reques
I (We) authorize you and the Financial Institution listed below to automatically deposit my withdrawals:
Checking Account—A voided check with a pre-printed name is required. Starter checks and deposit slips are not accepted.
Savings Account—A bank letter is required. Please provide a letter on your bank's letterhead, signed by a bank official, with your name, account number and routing number.
Should an inappropriate deposit be made, the Financial Institution is authorized to make debit entries to my account and
return to North American the corrected amount. This authorization will remain in effect until I have cancelled it in writing.
III. Financial Institution's Information
Account Number at Financial Institution Routing Number
Name of Financial Institution
IV. Acknowledgement
I (We) hereby acknowledge that the information provided herein is to the best of my (our) knowledge true and accurate. I (We) also acknowledge that this form must be fully completed, and failure to complete any portion of this form may delay the processing of the request. The completion of this form is necessary to satisfy the Written Notice Requirement as defined in Section 1 of the annuity contract. All Financial Institution account owners must sign.
Date Signed Date Signed
Owner's Signature
Date Signed
Joint Owner's Signature
North American Company for Life and Health Insurance® Mail to: P.O. Box 79905, Des Moines, IA 50325-0905

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Page 1 of 1 2018130

Overnight to: 4350 Westown Parkway, West Des Moines, IA 50266

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